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The Bancroft Library

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Berkeley, California

Government History Documentation Project
Ronald Reagan Gubernatorial Era

Lester Breslow

VISION AND REALITY IN STATE HEALTH CARE: MEDI-CAL AND OTHER PUBLIC PROGRAMS, 1946-1975

An Interview Conducted by
Gabrielle Morris
in 1984

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LESTER BRESLOW, M.D., M.P.H.

ca. 1984

TABLE OF CONTENTS -- Lester Breslow

On behalf of future scholars, the Regional Oral History Office wishes to thank those who have responded to the Office's request for funds to continue documentation of Ronald Reagan's years as governor of California. Donors to the project are listed below.

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PREFACE

California government and politics from 1966 through 1974 are the focus of the Reagan Gubernatorial Era Series of the state Government History Documentation Project, conducted by the Regional Oral History Office of The Bancroft Library with the participation of the oral history programs at the Davis and Los Angeles campuses of the University of California, Claremont Graduate School, and California State University at Fullerton. This series of interviews carries forward studies of significant issues and processes in public administration begun by the Regional Oral History Office in 1969. In previous series, interviews with over 220 legislators, elected and appointed officials, and others active in public life during the governorships of Earl Warren, Goodwin Knight, and Edmund Brown, Sr., were completed and are now available to scholars.

The first unit in the Government History Documentation Project, the Earl Warren Series, produced interviews with Warren himself and others centered on key developments in politics and government administration at the state and county level, innovations in criminal justice, public health, and social welfare from 1925-1953. Interviews in the Knight-Brown Era continued the earlier inquiries into the nature of the governor's office and its relations with executive departments and the legislature, and explored the rapid social and economic changes in the years 1953-1966, as well as preserving Brown's own account of his extensive political career. Among the issues documented were the rise and fall of the Democratic party; establishment of the California Water Plan; election law changes, reapportionment and new political techniques; education and various social programs.

During Ronald Reagan's years as governor, important changes became evident in California government and politics. His administration marked an end to the progressive period which had provided the determining outlines of government organization and political strategy since 1910 and the beginning of a period of limits in state policy and programs, the extent of which is not yet clear. Interviews in this series deal with the efforts of the administration to increase government efficiency and economy and with organizational innovations designed to expand the management capability of the governor's office, as well as critical aspects of state health, education, welfare, conservation, and criminal justice programs. Legislative and executive department narrators provide their perspectives on these efforts and their impact on the continuing process of legislative and elective politics.

Work began on the Reagan Gubernatorial Era Series in 1979. Planning and research for this phase of the project were augmented by participation of other oral history programs with experience in public affairs. Additional advisors were selected to provide relevant background for identifying persons to be interviewed and understanding of issues to be documented. Project research files, developed by the Regional Oral History Office staff to provide a systematic background for questions, were updated to add personal, topical, and chronological data for the Reagan period to the existing base of information for 1925 through 1966, and to supplement research by participating programs as needed. Valuable, continuing assistance in preparing for interviews was provided by the Hoover Institution at Stanford University, which houses the Ronald Reagan Papers, and by the State Archives in Sacramento.

An effort was made to select a range of interviewees that would reflect the increase in government responsibilities and that would represent diverse points of view. In general, participating programs were contracted to conduct interviews on topics with which they have particular expertise, with persons presently located nearby. Each interview is identified as to the originating institution. Most interviewees have been queried on a limited number of topics with which they were personally connected; a few narrators with unusual breadth of experience have been asked to discuss a multiplicity of subjects. When possible, the interviews have traced the course of specific issues leading up to and resulting from events during the Reagan administration in order to develop a sense of the continuity and interrelationships that are a significant aspect of the government process.

Throughout Reagan's years as governor, there was considerable interest and speculation concerning his potential for the presidency; by the time interviewing for this project began in late 1980, he was indeed president. Project interviewers have attempted, where appropriate, to retrieve recollections of that contemporary concern as it operated in the governor's office. The intent of the present interviews, however, is to document the course of California government from 1967 to 1974, and Reagan's impact on it. While many interviewees frame their narratives of the Sacramento years in relation to goals and performance of Reagan's national administration, their comments often clarify aspects of the gubernatorial period that were not clear at the time. Like other historical documentation, these oral histories do not in themselves provide the complete record of the past. It is hoped that they offer firsthand experience of passions and personalities that have influenced significant events past and present.

The Reagan Gubernatorial Era Series was begun with funding from the California legislature via the office of the Secretary of State and continued through the generosity of various individual donors. Several memoirs have been funded in part by the California Women in Politics Project under a grant from the National Endowment for the Humanities, including a matching grant from the Rockefeller Foundation; by the Sierra Club Project also under a NEH grant; and by the privately funded Bay Area State and Regional Planning Project. This joint funding has enabled staff working with narrators and topics related to several projects to expand the scope and thoroughness of each individial interview involved by careful coordination of their work.

The Regional Oral History Office was established to tape record autobiographical interviews with persons significant in the history of California and the West. The Office is under the administrative direction of James D. Hart, Director of the Bancroft Library, and Willa Baum, head of the Office. Copies of all interviews in the series are available for research use in The Bancroft Library, UCLA Department of Special Collections, and the State Archives in Sacramento. Selected interviews are also available at other manuscript depositories.

July 1982
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Project Director

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*Deceased during the term of the project

INTERVIEW HISTORY

Almost as soon as the 1965 amendments to the Social Security Act were passed, providing financial aid for health care for older citizens and for the medically indigent, the Medicaid amendment became a matter of fiscal concern. Medicaid was the designation for assistance that states could choose to provide to residents whose income was too low to cover medical bills, and for which the federal government would provide matching funds. In California, one of the few states to establish the optional program, it became known as Medi-Cal. Begun in the Pat Brown administration, Medi-Cal grew at a rate that made it a major budget headache throughout Ronald Reagan's years as governor.

One of the strong supporters of the legislation and of Medi-Cal was Lester Breslow, director of the California Department of Public Health from 1965 through 1967. In the following interview, Dr. Breslow provides a thoughtful discussion of the state's long tradition of quality health services, of the evolution of professional thinking in support of public financing of health care, and of the year when his statutory term as director overlapped Reagan's tenure as governor.

After twenty years in the Department of Public Health, during which he pioneered, in California and on national committees, in developing services for chronic disease control and preventive health care, Dr. Breslow was eager to implement the Medi-Cal program. "Our notion," he recalls, "was that here was this federal support for the first time, really, to match what California could well afford to pay for important services, health/life-preserving services for people for whom the state had responsibility. We wanted to make the best possible program."

With Paul Ward, Governor Brown's secretary of health and welfare, Breslow designed the program and prepared a budget for the first eighteen months of operation. Because of differences of opinion in the legislature and the medical profession as to whether Medi-Cal should be administered by the Department of Public Health or the Department of Social Welfare, the Office of Health Care Services was created in the governor's office to run the new program.

Before Medi-Cal reached its second budget cycle, Ronald Reagan was governor, and the program was experiencing cost overruns. The budget overruns added to the rising cost of welfare, which was a prime target of Reagan's 1966 campaign speeches and later of his efforts to cut, squeeze, and trim state expenditures. There was an initial effort to secure Dr. Breslow's resignation and that of other Brown appointees, but he stayed until the end of his term as director and succeeded in winning the respect of the new administration.

Although not in charge of the Medi-Cal program, he did establish a unit to monitor it. Interestingly, he was as concerned as the governor about the cost overruns. Where the governor's concerns tended to focus on the eligibility of recipients, Department of Public Health statistics indicated excessive billings by some physicians. Both of these viewpoints continued to have their partisans throughout the Reagan administration, which are described in interviews for the project with Earl Brian, second director of Health Care Services; Robert Carleson, Department of Social Welfare director; Roberta Fenlon, president of the California Medical Association; and others who played strategic roles in health and welfare reform efforts.

Dr. Breslow confines himself to discussing the impact of budget cuts and administrative reorganization on staff morale. The department, he reports, had been noted for the experience and stability of its staff; his successors, however, came and went frequently, and some did not even have public health training.

This interview was recorded in April 1984 in Dr. Breslow's office at the UCLA School of Public Health, where he began a new career upon retirement from state government. A medium size, cheerful person, still working a full schedule, the doctor addressed the interviewer's questions with vigor. "My Department," as he affectionately spoke of it, was still vivid in his memory as he concluded the discussion with some specifics of state prepaid health plans, hospital planning, and health care in minority communities. Dr. Breslow reviewed the edited transcript promptly and made minor revisions to clarify the text.

Gabrielle Morris
Interviewer-Editor

23 April 1985
Regional Oral History Office
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I PUBLIC HEALTH ISSUES, 1945-1964

[Date of Interview: April 5, 1984]##

World War II Medical Officer

Morris: How did you happen to come to California, since you're from Minnesota--that's a long way from California?

Breslow: I was born and went to grade school in Bismark, North Dakota; then to Minneapolis for high school, college, medical school, and school of public health. My (then) wife was a Californian. In the military service during World War II I spent one year in San Francisco with the family. After returning from overseas, I decided, both for personal and professional opportunities, to stay in California. My actual introduction came through K.F. Meyer, a great leader in public health at UC San Francisco, with whom I had had some contact during military days while stationed at San Francisco.

Morris: Were you stationed at the Presidio?

Breslow: I was stationed at the San Francisco Port of Embarcation, which functionally at the docks but which was physically housed at the Presidio.

Morris: I see. In charge of the health of the people going overseas?

Breslow: No, I was a preventive medicine officer for the Port of Embarcation. That required visiting the ships arriving from foreign ports for inspection to determine whether there was any communicable disease

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##This symbol indicates that a tape or a segment of a tape has begun or ended. For a guide to the tapes see page 76.

Breslow: on board. It meant going down early in the morning when the ships were out in the Bay, climbing up over the ropes on board, visiting the medical officer in charge, having a cup of coffee with him and ascertaining if there were any problems. So I climbed up a lot of ship sides in the Bay during 1944.

Morris: I believe it. This is incoming military troopships?

Breslow: Correct. Both army and navy. Anybody bringing back our troops, so both army and navy ships. We also sent physicians out on transports, outgoing. Because I was concerned specifically with preventive medicine, I did not get any such assignment. But after a year in the port, I volunteered to go overseas. I was assigned to the Seventh Infantry Division and spent time in Leyte and Okinawa, both of those episodes with the 7th Division, and then in Korea briefly after the end of the war and back to San Francisco. When I came back to San Francisco, I had decided to stay, if I could, in California. My notion was to introduce chronic disease control into public health.

Morris: This was not a concept that was--?

Breslow: It was a new idea.

Morris: Was this something you discussed with Dr. Meyer?

Breslow: I told Dr. Meyer about it when I returned and he was sympathetic, supportive. He telephoned Dr. Halverson whom he knew very well and made an appointment for an interview with Dr. Halverson.* My interview with Dr. Halverson was quite interesting. After all, I was there only because K.F. Meyer had requested it. Which meant in that case, demanded it.

Morris: Dr. Meyer was an autocratic sort of fellow?

Breslow: Very. A forceful personality. And I had worked with him and done some things which apparently had attracted his favorable attention during the early part of the war.

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*Wilton Halverson, then director of the California Department of Public Health.

California Public Health Director Wilton Halverson; Epidemiology and Chronic Disease Concerns

Breslow: In any event, I arrived with my notes prepared to explain to Dr. Halverson this new idea in public health, namely chronic disease control. Not that we had completed communicable disease control, but we'd advanced far enough against the communicable diseases that cancer, heart disease, and other chronic diseases were coming to the fore. We had to develop a public health approach to them. In some of the odd hours overseas and coming back, I had prepared a little prospectus of what a public health department should do about chronic disease.

Halverson sat at the corner of the desk with his chin in his hand, like that, and looked at me rather stonily as I was delivering myself of this proposition. After about eight minutes or so of a fifteen- or twenty-minute speech, I realized that it didn't seem to be making much impression. So I stopped and paused to give him a chance to ask questions or to have some interchange. I thought that might make the situation better.

When I paused, he just kept looking at me for a moment or two and then he said, I remember the words very clearly, "Dr. Breslow, why don't you go back to Minnesota and try out those ideas?" So, sensitive soul that I am, I felt somewhat rebuffed.

In any event, I went away on a little vacation, came back, and then went to see a member of the health department staff at that time, Dr. Jessie Bierman. She was a notable figure in maternal and child health, had been with the Children's Bureau in Washington and now was with the state health department. I told her what had happened a month before and that I was going back to Minnesota.

She said, "Well, don't hurry. Spend a few more days, because there is a new person here. It would be worth your while to meet him. That was Dr. Robert Dyar, who had just that month come into the department as Chief of the Division of Preventive Medical Services. She arranged an appointment for me to meet Bob Dyar, and I made the same speech for Dyar.* He listened to all of it with some facial signs of more interest.

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*These ideas were subsequently written:

Breslow, L., "Chronic Disease in the Modern Public Health Program," California's Health, 5:277-280, 15 December 1947.

Breslow, L., "A Health Department's Role in the Cancer Program" California Medicine, 68:5, May 1948.

Wilton Halverson, Lester Breslow, Malcolm Merrill, "Chronic Disease: The Chronic Disease Study of the California Department of Public Health," American Journal of Public Health, 39:593-597, 1949.

Breslow: At the end of it, he said, "Dr. Breslow, have you had any experience with encephalitis?" And I replied, "Yes, I have had a little, as a matter of fact, but my interest is in chronic disease control."

"I understand that. I would merely like to know if you have had any experience with encephalitis."

I said, "Well, in Minnesota, we had a large outbreak in the early 1940s, and I spent one summer doing field work on the problem. Also, in Okinawa during the spring of 1945 we had an outbreak of encephalitis, and I worked with the Naval Medical Research Unit investigating the epidemic. So I have had that much experience."

He explained, "We have an important project that the legislature has just asked us to undertake, namely, the investigation of encephalitis in California." At that time, there was quite an epidemic. Encephalitis is a virus disease spread by mosquitoes; principally to horses, but also in some cases to man.

Morris: With high fever and--

Breslow: Yes. And you can have brain damage and death from the disease.

"So, we have this important project to investigate encephalitis. I think that's something you could undertake, and we would like to have you do it."

I said, "But, Dr. Dyar, you understand what my interest--"

"Yes, I understand your interest very well, and I'll tell you how we'll accommodate that. Encephalitis occurs in the valley--the Central Valley of California. You will have to spend many days down there investigating cases. And at night, you stay in motels in these small towns. There is nothing to do in those small towns. Not even a movie to see. So you can write memos about chronic disease at night after you've investigated the cases."

I asked, "Will anybody read them?"

And he said, "Yes, I'll read them."

"Will anything come of it?"

"I can't tell you that, but we can both hope so."

Breslow: So it was agreed. I began in January of '46, taking on the job of encephalitis investigation. And that led into the summertime, June 1946, when there was a big epidemic of poliomyelitis in Los Angeles. Halverson one day called me. All this five months or so that I'd been around the department, I'd been very careful not to encounter him in the hallway or anything, [laughs]

Morris: So Bob Dyar hired you and you didn't have to go back and be approved--?

Breslow: I presume Halverson knew about it, I don't know. In any event, I had no personal encounter with Halverson until one day early in June, he called me into his office and I thought, "My gosh, now he's discovered me!"

He said, "I'd like to have you go down to Los Angeles"--I remember the words--"and take charge of the epidemic of poliomyelitis in Los Angeles."

Morris: That's an interesting phrase.

Breslow: I wanted to know what that meant, and he explained to me it was, literally, taking charge for the state health department, representing him in Los Angeles, and being the decisionmaker on all of the state involvement in the epidemic, responsibility for which was principally a local operation at the time.

So he personally took me down to Los Angeles the day he was leaving on vacation, introduced me to some of the key people, drove me around in a great big automobile that the state provided for the state health director in those days. At the end of the day he asked me to drive him out to Glendale, which was his home. He was leaving on vacation, gave me the keys and said, "It's very important to drive this car around because then people will know you're the state health officer."

Morris: Did it have a seal on the door?

Breslow: I don't remember, I don't think it did. I think it was just a big car that, around town in those days, people recognized. So that was how Halverson accepted me, I guess.

Morris: That was quite a responsibility for a new young man in the department.

Breslow: A kid. That's right. I won't discuss all those details. It would take another whole hour. But, just chronologically, in August, while I was still in Los Angeles on this assignmemt, Dyar called me and said, "Remember those ideas you had about chronic disease?"

Breslow: I said, "Oh, I remember them very well!"

He said, "Well, it looks as though we may be able to do something about it."

"How's that?"

"Well, the federal government has just allocated funds to the states to develop cancer-control programs. And we can do it more or less any way we want to. So I'd like you to come back and talk to me about how we should do it."

So we decided to start a chronic-disease program, and established a Bureau of Chronic Diseases in the state health department. Cancer would be the first focus, but we anticipated, as happened, that attention would subsequently be given to heart disease and other problems.

So that's how I entered the department and became the Chief of the Bureau of Chronic Diseases during my first year, 1946, in California with the state health department.

Morris: Did Dr. Halverson, in general, leave this kind of decision about operating programs to the bureau chiefs?

Breslow: Largely, yes. You may be interested in how he operated and came into the department. Dr. Halverson was a Seventh Day Adventist, trained at Loma Linda Medical School, and subsequently in the East, I think at Yale, in public health. He then had returned to California to be the health officer of Pasadena, subsequently for Los Angeles County. In the early 1940s, Earl Warren became governor. Warren was determined to build an excellent state administration. He picked people who were highly competent in their fields, who had reputations--state, preferably national--who would be on the front line in their fields of endeavor. If you've investigated Warren's administration, you must have found that that is exactly what happened to a very great extent.*

There were state health departments in practically every state, but in California, as in many other states, they were of low esteem. I don't know too much about those in other states, but there was

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*See interviews in Earl Warren and the State Department of Public Health, Regional Oral History Office, University of California, Berkeley, 1973.

Breslow: no reputation for public health in California state government. Warren was determined not just to make a reputation, but to do a good job for public health. So after a careful survey with the best advice he could obtain, it is my understanding, he asked Halverson to head the department.

Halverson took the position on one major condition, and that is that the governor would seek, and it was obtained, a law which would establish a statutory term for the state director of public health. That term would overlap by one year an incoming governor's term. The idea was that, while an appointive position by the governor, the paramount criterion for the position would be technical competence. Also, any new governor would at least have to spend a year with the prior director of health. He might then find, whatever his political intentions might have been coming into office, that, in Public Health, he should have a technically competent person to head a professionally well-reputed and well-established organization.

Morris: With some continuity.

Breslow: Correct, with continuity. And that agreement between Halverson and Warren continued from early 1940s till 1967. I can give you a synopsis of what happened.

Strengthening the State Department of Public Health

Breslow: Halverson did build up the department, selecting people of competence like Bob Dyar and advancing those whom he found in the department to be very competent. One of the latter was Malcolm Merrill, who had been in the department before Halverson arrived, as a microbiologist and laboratory person.* Halverson recognized Merrill's administrative competence and wanted his help in building the department.

By 1946, the department was really well established and organized with Halverson as the director; and Merrill, incidentally a Mormon, as the deputy director. Merrill was a very close co-worker with Halverson. They had absolute trust in one another; and they recruited some excellent division heads including Bob Dyar in Preventive Medicine, Frank Stead in Environmental Health and subsequently, Howard Bodily for Laboratories and Bob Webster for Administration. So they had very strong division heads.

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*Ibid., interview with Dr. Merrill; Merrill had joined the department in 1937.

Breslow: Then each division head would build the bureaus. It was a very hierarchical arrangement; we had staff meetings, including the bureau chiefs: the staff meetings drew, while I was there, I guess, twenty to thirty-five or forty people, including the directors and bureau heads.

Morris: And Jessie Bierman? Was she a medical doctor?

Breslow: Yes. Her original training was in pediatrics and she was a notable figure in the development of maternal and child health programs. First in Washington in the Children's Bureau, then in the California Department of Public Health, she was recruited to head the Bureau of Maternal and Child Health.

Morris: Did Dr. Halverson go out looking for her?

Breslow: I'm not sure whether Halverson or Dyar recruited her. It must have been Halverson, because she was there at the time Dyar came on. I don't know whether Dyar was involved with consulting on that or not. You see, Dyar was in the military also. I never knew how much he had worked with Halverson before he took, officially, the position as chief of Preventive Medical Services, but--

Morris: Looking back on it now, did you realize that this was a woman at a time when there were few women in the field?

Breslow: That's true. There was another woman in the department early on, Dr. Marcia Hays, who headed the crippled children's program of the department. She developed a very great service, another bureau in Preventive Medical Services.

Morris: So you went from encephalitis to polio and--

Breslow: That all happened within a year.

Morris: Within a year.

Breslow: Then went into chronic diseases.

Morris: Then went into chronic diseases.

Breslow: Specifically cancer, at first, because the money was allocated for cancer; so of course, we had to develop the program principally for cancer.

Morris: Then how did this lead into or relate to the President's Commission on Health Needs of the Nation? Was California lobbying for a national study of the concerns on the West Coast of the general state of--?

Breslow: There was no connection--may I say something before I answer that? About the department.

Morris: Sure.

Breslow: I would like to respond to one of your implied queries, namely the stability of the department. Beginning with Halverson's administration, it must have been about '42 when Warren came into office, or very shortly after Warren came into office--

Morris: Yes, I think Dr. Halverson was one of his first appointments.

Breslow: Correct. At that time Merrill was his deputy; Merrill took over as director of the department in the early 1950s, I believe, when Halverson became ill and subsequently died. Merrill continued as the director until 1965 when he decided to move to Washington to take a position in international health. That was during Pat Brown's administration. I had been in touch with Governor Pat Brown when he was county attorney, even before he was state attorney general, through a mutual interest in doing something about alcoholism as a public health problem. To fulfill the term which ran until 1 January 1968, one year into the new administration, Brown asked me to complete that term. Thus, for twenty-five years, from 1942 to 1968, there was continuity in the department leadership. During that time there were only three directors who worked closely together for almost all of that period. Most changes in division or bureau leadership were due to retirement or promotion.

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Breslow: Merrill was in the department from the late 30s, Halverson came in the early 40s, I came in '46. So there was that continuity. All three, to indicate that Warren's original idea couldn't have been totally wrong, came onto the national scene. For example, all three of us served as presidents of the American Public Health Association. That gives one indication of the nature of the department and the way that it was regarded nationally. A lot more could be said, but I think it is fair to say that it was one of the strongest state health departments that developed in this country in this century thus far. I just fell into it, for the reason I explained.

Morris: I have wondered if somehow the stability of it didn't attract people--

Breslow: It did.

Morris: --who had an interest in long-range, pioneering kinds of programs.

Breslow: Right. For example, three of the people whom I was involved in recruiting went on to quite important university assignments. Leslie Corsa, who just died, was chief of Maternal and Child Health and went to Michigan to head up a notable population program in the University of Michigan School of Public Health. Nemat Borhani, whom I recruited from Johns Hopkins to head up our heart disease program in the Bureau of Chronic Diseases, left to head the community medicine department at the University of California, Davis, Medical School. He's still there. Bob Day, whom I recruited to succeed Corsa in Maternal and Child Health, went on to become a professor and then dean of the School of Public Health at the University of Washington in Seattle, and has since moved to become the director of the Comprehensive Cancer Center in Seattle. Those are just three examples that come quickly to mind of the kind of people who were in the department. It was a first-rate group and with very high morale.

Morris: And in those years, your headquarters were in San Francisco, weren't they, and then in Berkeley?

Breslow: Yes, we moved to Berkeley, well, in stages. I think I went to Berkeley in '47 or '48, something like that.

President's Commission on Health Needs of the Nation, 1950: Individual and Government Responsibilities

Breslow: You asked about the President's Commission. The department had little to do with that assignment except to grant me leave for the year. That assignment came in a much more personal way. President Truman, frustrated at not being able to carry out his agenda for national health insurance, in his final year in office appointed a commission to prepare a report on health needs in America. It was headed by Paul Magnuson, a Chicago orthopedic surgeon and a man in personality very much like Harry Truman.

The commission had some excellent people on it. Chester Barnard of the telephone company was the vice chairman under Magnuson; Walter Reuther was a member of the commission; Russel Lee, the California physician who was head of the Palo Alto Clinic; Evarts Graham, the St. Louis surgeon who was the first to remove a lung for lung cancer; Joe Hinsey, dean of Cornell Medical College; and others They were first-rate people, all of them.

Breslow: In any event, that group met several times for almost a year. One day, a month or so after the commission had started work, I had a telephone call from Russ Lee. He wanted to see me. I didn't know him personally, but was flattered to be called, so I went to Palo Alto to visit him. He explained to me that three members of the commission--Lee and Lowell Reed, who was then the president of Johns Hopkins, a notable figure in public health; and the head of the machinists union, a man named Hayes, had formed a little committee within the commission. They were dissatisfied with the staff selections of Magnuson. He had picked some people from the Veteran's Administration and they just didn't seem to have the kind of talent that these three committee people were looking for. So they had decided that I should become the chief of staff.

Morris: Of this study.

Breslow: Of the study.

Morris: Was the man from the machinist's union also a Californian?

Breslow: No, he was from the East. But Lowell Reed knew me, and Russ Lee at least knew me by reputation, I guess, in California. I think Lowell Reed may have suggested me, I don't know.

In any event, I explained to Russ Lee about eight or ten reasons why I couldn't take the job, although I was very flattered to be considered: I couldn't get a leave from the department just like that; I didn't want to leave my family and not have a chance to visit them over ten months, and there was no way of taking them there (the children were in school already); while I wasn't getting all that much in the department, it was just economically impossible for me to do it; and so on. I gave a lot of reasons that just made it completely unfeasible. But I expressed great honor.

Morris: Was that a fishing expedition, or did you really not have that much interest in taking on the study?

Breslow: Oh, I really thought it was just impossible. It was just as if they came to me today--"You are going to be on the next flight to the moon." It might be a nice adventure, but I'm not--

Morris: You didn't really think about it--

Breslow: No. It was just out of the question. Two weeks later, Lee called me up and wanted to see me again. I asked, "Well, what about?"

Breslow: He said, "I'd just like to discuss these matters with you." [laughs]

So, okay, I didn't know what there was to discuss, but I went down there. We sat at the same desk that we had sat at before and he had the same envelope on which he'd written these items down, and he said, "Your first problem was getting leave from the State Board of Health. Here's a letter from the president of the State Board of Health granting you leave for the year. Your second problem was getting to see your family often enough and when you wanted to. Here is a book of TRs."

Perhaps you know that now, when you travel for some government agencies, they will send you a travel request which you take to the airline and exchange for a ticket. But at that time, he didn't give me a ticket, he gave me a book of blank tickets.

Morris: Which you did use?

Breslow: [Lee said,] "Any day of the week that you decide you want to see your family, just go down to the airport, get the next plane and go to California. And the pay. Now that's a little more difficult, but you see, on this job you're going to have to work weekends as well as every week day. So we are going to pay you seven days a week. If you figure that out, it comes out to just about what you're making now. We realize you're not going to get rich, and that's not the intent, but at least it covers your salary and enough to have an apartment in Washington."

And so on. He went right down this list, and he had every item covered. So [laughter] I took the job, of course, and went on--.

Morris: That's in the nature of an offer you can't refuse.

Breslow: Well, I'd set all the absolute conditions that made it impossible and he'd met every one of them, including taking over the personal leadership of the staff during the week late in the fall when the report would be coming along and I wanted to go to the American Public Health Association annual meeting. I wasn't going to miss any of those meetings, and he said he would come to Washington to do it. And he did.

Morris: Russel Lee, himself. Left the clinic in Palo Alto?

Breslow: Spent a week at my desk as the head of the commission staff. That's another whole set of stories.

Morris: Yes, he was a very great man.*

Breslow: A very colorful man.

Morris: Had any kind of study like this been done before? Was there data to draw on?

Breslow: Oh, there had been a great many studies. Probably the greatest study in America in the field of medical care, prior to that time certainly, and which exceeded in many ways what we did, was by the Committee on the Cost of Medical Care. That had been appointed in the late 1920s and was headed by Ray Lyman Wilbur.

Morris: When he was Secretary of the Interior, or something like that?

Breslow: I forget what position he was in then, but he was the chairman of the Committee on the Cost of Medical Care. It, too, had notable figures. Some great people in American public health and medical economics, medical care studies participated, particularly a man named Ig Falk.

They issued a multi-volume report which had a considerable impact on thinking, unfortunately among only a very narrow group of people. But as an historical document, it is a very important piece. And there were many, many other studies that were to be pieced together for our report.

Morris: So were you using that data for the America's Health report or did you go out and get new additional--?

Breslow: We did no original data collection. We had a considerable staff. Again, we were fortunate to have some truly excellent people. My interest in it, as I saw the task and realized the opportunity, was to see whether, with the commission, we might introduce some new thinking about health; what to do about it in this country.

I was taken especially with something I had read by Henry Sigerist, the medical historian who had been at Hopkins for some time. By that time, I'm not sure whether he had already left to return to Europe. In any event, he had done some pioneer thinking on the nature of health services. And, without attributing it especially to him, although there was no secret about this, I used

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*See interview with Russel V. Lee, "Pioneering in Prepaid Group Medicine, in Earl Warren and Health Insurance, 1943-1949, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1971.

Breslow: the concepts that Sigerist had advanced in some studies of health in other countries. I used them to formulate the work that we would do on this commission. The principal idea was that we should look upon health services as encompassing a spectrum of activities: the first element would be the promotion of health; the second would be prevention of disease--specific disease prevention; then diagnosis and treatment; and fourth, rehabilitation.

That was the principal theme of this report, and I've always thought the greatest contribution that it made. Other people would probably turn to our discussion of health personnel and health facilities, the organization of health services, financing, or other items that were then much more attractive and in the public eye.

Morris: Did you ever have a chance to talk to Harry Truman about where he was coming from, as they say now?

Breslow: No, the only contact we had with Truman was delivering the report, and I've only a vague recollection of that. I think it was one of these garden receptions or something like that.

Morris: Were these ideas that you were developing ideas that were shared by many of your colleagues in public health at that time? Were they discussed at some of the public health conferences?

Breslow: I can't say that. I believe they were ideas of a quite narrow group of people in public health. I don't mean narrow-minded, but a small group of people. But we wanted to get beyond the notion that all that mattered about health was having doctors and hospitals and drugs. They were important essentials, but a broad approach to health for the American people encompassed this whole range of activities, each of which we defined quite carefully.

Another important idea that we introduced, I think, was the notion of individual responsibility for health which at that time was not getting very much attention. Since that time, it's received a lot of attention, of course.

Morris: It is, if you'll pardon the word, it's almost trendy in the 1980s.

Breslow: Right. May I read what we said about it, just two or three sentences?

> "Future accomplishments, however, depend to an even greater degree upon the individual's assumption of responsibility for his own health (that is, a greater degree than dependence upon other people, physicians or others, environmental matters).

Breslow: It is the individual who must consult his physician for early care, avoid obesity, alcoholism, and drive his automobile safely. These things can not be done for him. They require both information and motivation....

> "Recognition of the significance of individual responsibility for health does not discharge the obligation of a society which is interested in the health of its citizenry. Such recognition, in fact, increases social responsibility for health. Heretofore, social effort in behalf of health has been limited largely to such measures as delivery of pure water to the individual's tap and the sanitary disposal of his sewage. Now it becomes necessary for a society which wishes to advance the health of its citizens to adopt measures which guarantee to the individual an opportunity to make appropriate decisions in behalf of his health."*

Now, looking back, I'm rather proud of our formulation. As you know, a whole debate has arisen around this notion of personal responsibility for health. The idea has been advanced that emphasizing such responsibility is, in effect, "blaming the victim." For example, a person who's suffering from advanced alcoholism may be blamed because he has chosen to follow habits which resulted in this bad health situation. Some of us have felt--not in the last six months or six years when this idea has become, as you say, trendy, but for thirty years--some of us have thought quite differently about the relationship between the individual and society with respect to habits that affect health.

Morris: I'm struck by something else, too, since I'm coming at this from the perspective of the years when Ronald Reagan was governor. Personal responsibility is something that has been one of the Reagan and Republican approaches to policy administration, and there I hear the idea that if it is an individual responsibility, then it is not a government responsibility.

Breslow: That is another misconception: there is no contradiction. It is not one or the other, individual or government; but the individual obviously has an interest in his own health, and good government also has an interest in the health of all its citizens. This should be a partnership, if you will. In fact, another element of the partnership should be the physician.

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*Building America's Health, A Report to the President by the President's Commission on the Health Needs of the Nation, 1952, Vol.1, p. 1.

Breslow: And here is another point which I think is quite current, when the promotion of health is again coming into prominence, is becoming a national slogan. Each of the past several secretaries of Health and Human Services, even of the preceeding departments with the same cabinet position, has espoused health promotion as an important element of health policy. We put the promotion of health at the beginning of the spectrum, and here's how we defined it:

> "All of those measures aimed at improving the health aspects of the environment in which peoople live, and at improving health practices constitute the promotion of health. Better housing, better nutrition, better working conditions, better education, will enhance the health of our people just as certainly as will better physician's care."*

So in our notion, promotion of health is not some kind of PR campaign, but solid efforts to improve the conditions in which people live so as to guarantee them the opportunity to make appropriate decisions for health.

Morris: That sounds very impressive.

Breslow: I could tell you a great deal more about our report. For example, analyzing the situation of the various kinds of health personnel, we saw the need in 1952 for a larger supply of physicians for the American people, and we recommended that. On the other hand, we also saw the possibility of there being too many physicians, even in those days. So we recommended a very modest increase in the numbers of physicians, on the order of magnitude of 10 or 15 percent, in relation to the population that was to be served. We did not contemplate the tremendous expansion of the production of physicians in this and other countries which has now led to what most people recognize as a superfluity of physicians.

Morris: In the United States.

Breslow: In the United States, that's correct. We also noted that the way medical care was organized could make a substantial difference in the number of physicians who might be needed: "There is considerable indication that improved organization of medical services could make good medical care possible with fewer physicians than are now available in some of these areas."**

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*Ibid., p. 53.

**Ibid., p. 13.

Breslow: Even in those days, 1952, we foresaw a good deal of the problems that were to arise and the debate over the next several decades. Looking back at a document like that is to me, a matter of some interest.

Morris: Yes. So when you came back to California, were you inspired to try to implement some of these ideas that you had pulled together and explained?

Breslow: In those days, you may remember or have read about, the political climate in this country was not conducive to social advances, generally. There did not seem to be much opportunity in California at that time nor in the country as a whole to move in these directions. So our report got, in effect, filed. What's kind of interesting is it's an historical document.

Morris: You mean, Truman appointed the commission--

Breslow: But the report was delivered at the very end of his administration. In effect, it was handed over to Eisenhower because he became president immediately thereafter.

Morris: But it had no base of congressional interest or support?

Breslow: No. The Congress in those days was more interested in one of its own members--Senator [Joseph] McCarthy, and other issues.

Morris: Yes, but there had been--what about the National Commission on Mental Illness and Mental Health?

Breslow: Some things were done. As a matter of fact, I went back about five years after the publication of our report (I never published this, but I did it for my own private edification), and found that substantially all of the recommendations that we had made had been placed on track. In some of them, a good deal of progress had been made. Mental health was one of them. But the idea of a comprehensive plan for health and going at it in a bold and inclusive fashion never materialized.

Morris: Was there an opportunity to feed some of these ideas back into the journals of public health?

Breslow: Oh, yes. The document did serve that purpose--it tended to, I think, mobilize to some extent and certainly to inform people in public health and in related fields that it was possible to think rationally and systematically about what should be done for health. That was done to some extent, but never in the fashion that we could fancy.

Morris: You were given carte blanche to say what if we had things exactly the way they ought to be this is how we'd like them?

Breslow: Well, we made recommendations in every one of these areas that I've mentioned and some others: personnel and facilities, medical research, medical education, and the organization of services. We made recommendations in all these customary fields.

Morris: And did you see to it that Governor [Earl] Warren and then Pat Brown got copies of this?

Breslow: Oh, yes, they were distributed. I don't know how widely, because the government wasn't interested in distributing it very widely. Really. And not many copies were distributed. You find them in a few libraries but it's rarely referenced.

Evolution of County Hospitals, Health and Welfare Departments; Discontinuities in Medical Care for the Poor

Morris: My limited research in this field shows that in California by 1957, I think it was, there were federal funds for medical care for the aged and PAMC.

Breslow: Public Assistance Medical Care.

Morris: Where was the support coming from for there to be some funding for general health care for--?

Breslow: Poor people.

Morris: Poor people, at least.

Breslow: That idea rose out of welfare thinking and welfare circles. You mentioned John Wedemeyer earlier. He typified the welfare people of that day, also Wilbur Cohen on the national scene; Charles Schottland, another great figure in California's welfare movement, and so on.

We recommended medical care along those lines. As a matter of fact, some of the members of our commission footnoted opposition to our statement, which they felt was too state-oriented and too public assistance-oriented for their taste.

Morris: That's the America's Health report?

Breslow: It was called Building America's Health; it was too conservative for three members of our commission who signed a minority report. We had a few minority reports that took the form of footnotes.* That's the way we worked it out.

Morris: That's a good way to do it.

Breslow: You asked the question, how did the PAMC come in? My perception of how it happened was that the people in the welfare administration were ahead of those in public health in seeing the need to provide medical benefits, which were now becoming quite important. Physicians could really save lives by that time. And hospitals were places to have babies and operations, and so forth. So having access to the medical care system, as it has come to be called, was important. Welfare recipients, by and large, were limited in their access to medical care, especially in the urban areas.

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Breslow: Their leaders recognized that the medical care which their clients were receiving in community tax-supported hospitals was pretty dismal, compared to what the rest of the people had available. So, to achieve greater equity for the people in whom they had professional interest, welfare leaders sought and obtained what were called in the early 1950s vendor payments for medical care as a supplement to public assistance.

Vendor payments went for limited medical services to practitioners who were outside of the local government service. In other words, the arrangement would permit a welfare client to go to a private doctor's office. That movement began and slowly expanded through the '50s. It was called, in California at least, Public Assistance Medical Care and was administered through the welfare department as a supplement to the cash-benefits program. It was for welfare clients and was regarded as something for which the welfare department should take administrative responsibility. Unfortunately, they knew little about health or health care and didn't read much about it. There was relatively little contact.

Morris: They didn't come to the Department of Public Health for some consultation?

Breslow: No, not really. Various efforts were made and there were some desultory agreements; and here and there, there were even, in the country, some joint enterprises. But they rather jealously guarded the idea that they were the only ones who had the right attitude to

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*Ibid., pp. 21, 49, 52.

Breslow: protect the health of poor people. They would use these funds, and they were quite limited. They were nothing like we got into in the 1960s with Medicare and Medicaid, but that's getting ahead of the story.

Morris: The county hospitals: did they relate to the state Department of Public Health?

Breslow: Only in that they were required to have a license from the state Department of Public Health, but they were locally administered, responsible to the county boards of supervisors. They probably had a closer working relationship to the state Department of Social Welfare than to the state public health department.

Morris: Once this--?

Breslow: PAMC thing came along, it had to be carried out in juxtaposition to the locally administered medical care services.

Going way back into the last century, as you may know, California had an indigent medical care law placing upon the counties the responsibility for providing medical support to people who could not otherwise obtain it. And the counties' way of meeting this responsibility was to build what really became for some years, and its time, a quite magnificent set of county hospitals.

Morris: In talking to people in the field of welfare--local and state--the impression I get is that the state Department of Social Welfare's constituency is the county welfare departments.

Breslow: Yes.

Morris: And that they are very strong relationships.

Breslow: That's right.

Morris: I'm interested that it's not that way in Public Health.

Breslow: Oh, Public Health did have such a constituency and, as a matter of fact, it was developed under the leadership of Malcolm Merrill. In addition to the state Department of Public Health, we had in those days--still have--county health departments. And they carried out a range of public health services in a county: certain clinical services for infants and mothers and children, immunizations, environmental health services, health education services, health statistics--all of these things were functions of the county health departments.

Morris: But they don't relate to the county hospitals.

Breslow: No. They are quite separate.

Morris: County hospitals are a separate institution?

Breslow: Correct.

Morris: Okay. Because that seems odd from a layman's point of view.

Breslow: Really.

Morris: Yes.

Breslow: It seems very odd, I would say, from a sophisticated public health point of view, too. It's crazy. You see, what happened historically was, that welfare departments grew up for reasons you can understand--let's speak about California only--to provide the state and local, later federal, cash assistance to people and certain social services beyond cash assistance. Health departments grew up to protect people against epidemics.

Morris: Yes. The sewage and the clean water--

Breslow: Correct. Immunizations, then later protection of mothers and children, and it gradually spread. So most counties in California began to develop health departments. But they were of a variable nature.

Morris: Not providing patient care.

Breslow: Only to very limited degree. For example, poor pregnant women could come to health department clinics and then bring their babies. People with tuberculosis or venereal disease could come to health department clinics for treatment, because that was regarded as a part of the public health responsibility; but people who could afford to go to private physicians, even for tuberculosis or venereal disease, and certainly for prenatal care and infant care, would go to private doctors' offices. The health department was given the responsibility by society, the state and counties particularly, to provide these services--some clinical, but mostly non-clinical services: environmental, health education, and the like.

Now, what Merrill did was a notable achievement in California. It came as a result of his doing a stint in the graduate School of Public Health in Berkeley while he was deputy director of Public Health. He'd been trained only as a laboratory man and Halverson,

Breslow: his chief, had a doctorate of public health. So Merrill decided to get a graduate public health education. On a part-time basis at Berkeley, he got his public health degree. His thesis was how the state could help local health department development.* His idea was that the state should provide a subsidy to local health departments which met a state standard of structure and performance.

A state subvention which went to the counties, the amount depending largely upon their population size, required the counties, if they wanted the money, to meet a state-defined standard in local health department services.

Morris: To upgrade county health departments?

Breslow: Correct. That was a tremendous stimulus to the development of local health departments in California. It eventuated in the development of a Conference of Local Health Officers in California which helped to define these standards and to advise the state on the further development of the program. So we had a very strong link between the state and the local health departments.

Now, to get to your earlier question, besides the welfare departments and the local health departments which grew up for quite separate reasons, although they had some cross-client interest, some of the same people at the welfare department came to the public health department for pre-natal care or tuberculosis or had their houses inspected and so forth. Then the third element was the county hospital which grew out of early legislation in the state.

Morris: It was a linkage back to--

Brewlow: Way back to the last century, yes. The local government is responsible for the medical care of the indigent. And the counties met that responsibility in California in what was for a good long time and for those days especially quite an excellent way, namely, the development of first-rate county hospitals with training of physicians and linkage to medical schools. That latter element continues to the present time.

But those three were not linked. They were quite separate in those days: in the forties and fifties.

Morris: Because each had been developing on its own basis.

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*The Fiscal Relationships of the California State Department of Public Health to Federal and Local Government Agencies, thesis, MPH, University of California, Berkeley, 1946.

Breslow: Exactly. Later, people began to see what you obviously see--"My goodness, why don't these get together?" So you began to encounter, particularly in the sixties, the amalgamation of health departments and county hospital systems. That happened in Los Angeles County; it happened in several other counties of the state. In some instances, umbrella agencies, so-called, were formed in the counties as well as in the state, to encompass health, hospitals and welfare.

Morris: Can you give me an example? Is that like a joint powers agreement, or is this a separate kind of a structure?

Breslow: Well, the state, for example, for some years has had a Health and Welfare Agency which includes the Department of Health Services. It also includes other departments.

Morris: That's at the state level. Right. I misunderstood you, I was thinking of some county.

Breslow: Same kind of thing, some counties have moved in that same direction. And particularly there has been a combination of health and hospitals, not extended so much to welfare, but in many places in the state, health and hospitals have been combined and then uncombined--there have been various efforts to bring those somehow into juxtaposition and together administratively.

They do have some different clientele because the county hospitals have been focused on poor people, those who are receiving welfare assistance. The health department has its clinical services largely directed to that same group, but not entirely, because they may do some school work for the whole population. The health department has a larger focus, onto the whole population.

New Concepts of Chronic Disease Measurement and Control

Morris: Well, it's not as if epidemiology changed considerably during this period we're talking about. They go from counting chicken farms and encephalitis cases to counting cases of the social diseases.

Breslow: A good thinker in public health, Milton Terris has called what you are now mentioning the Second Epidemiologic Revolution. Joseph Califano, in office [as secretary of HEW], called it the second public health revolution. It was moving from concern with the communicable diseases to the major diseases of the latter half of the twentieth century.

Breslow: But that's taking us off track.

Morris: I hope my colleagues at the UCLA Oral History Program will come back and talk to you in more detail about some of these things.

Breslow: Oh, I understand, I'm just trying to respond to your question. Well, let's get on with your task here.

Morris: Yes. Now you became director of the State Department of Public Health.

Breslow: I came back to California after the President's Commission Report at the end of 1952. I think you asked me what I did about the President's Commission Report in California. The answer is essentially nothing, except to absorb it into my thinking and use its concepts in trying to convey to my colleagues in California and elsewhere what the health problems of the country were. Because in that year of study under the commission (and there were great people on that commission and having responsibility for assembling the report), I learned a great deal.

In any event, I came back and was immediately interested in advancing our knowledge of chronic disease as a public health problem. That was a great concern because it was by no means established as a public health problem. I mentioned to you earlier what Halverson said to me when I tried to introduce it. Well, I was invited to write a chapter on the topic for the then, and still, leading textbook of public health in this country. It was started by Milton Rosenau back in the first decade or two of the century and will soon go into the twelfth edition.* The editor of the seventh edition (1951), Kenneth Maxcy, asked me, picked me out of the country as the person, to write a chapter on this new field--concern about heart disease, cancer, all of the chronic diseases. I proposed a chapter on chronic disease control, I think I said.

He said, "Oh, no, there's no such thing as that. The chapter will be "The Diseases of Senescence."

And I argued with him. I said, "They are not diseases of senescence. Some people get them when they're thirty or twenty. And we ought to attack them the same way we attack all diseases."

"No, the chapter will be headed "The Diseases of Senescence."

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*The most recent, eleventh edition was John M. Last, Maxcy-Rosenau, Public Health and Preventive Medicine, Appleton-Century-Crofts, 1980, New York.

Breslow: If you go back to the seventh edition (Maxcy), you'll find a chapter there on "Senescence, Chronic Disease, and Disability in Adults." That was the common view.

My next aim was to get a better perception, a better understanding, and that meant measurement of chronic disease as a health problem. So in the early fifties, we started to develop methods for measurement of chronic disease in the general population. I hit upon the population survey method as others had earlier--I wasn't the first one to do this. As a matter of fact, it had been done to some extent as early as the late 1920s, and again in the thirties in various parts of the country. There was a big WPA project in the thirties--to survey the health of people. I wanted to focus especially on the survey method as a means of acquiring information about the nature, extent, and distribution of chronic disease in the population.

Morris: Using California as your population--your data base?

Breslow: Beginning with California as a whole. We found a number of surveys from other places but we discarded them as not applicable. We then worked with people in the Public Health Service who, ultimately, came into leadership of the National Center for Health Statistics and carried out the National Health Survey beginning in 1957, and subsequent surveys that continue to this day. Some of those federal people came out here to help us as technical consultants.

Morris: Did you design the statistical surveys for use here in California?

Breslow: Yes, our group did. Some of the questions that we designed for the California survey are still included for the National Health Survey. We were not the only ones to do this kind of thing. It was done also in Hunterdon County, New Jersey; it was done in Baltimore, Maryland. During this same period, the early 1950s, the Commission on Chronic Illness nationally came into being. It was sponsored jointly by the American Medical, American Public Health, American Hospital, and American Public Welfare Associations. I was the editor of Volume 1--the volume on prevention for that commission report.*

So the thing was beginning to get a little steam nationally, but some of the notions we still have, such as primary and secondary prevention of chronic disease, I introduced during the work of the Commission on Chronic Illness. Again, it had a number of really notable people in the health field. As a relatively young person, I was very privileged to work into that and to see and help develop some of the notions.

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*Chronic Illness in the U.S., Commission on Chronic Illness, Harvard University Press, 1957.

Morris: That must have been very exciting.

Breslow: Yes, it was.

Morris: So you're saying this is a parallel development to the Building American Health report?

Breslow: Yes, except that Building America's Health was a presidential initiative. And the Commission on Chronic Illness was an initiative of these four professional organizations. They raised the money from private sources and had some staff and did the work, and some of us who worked on the commission as consultants in various ways--I did it in several ways--learned a great deal and were able to help formulate the notion of how to approach chronic disease as an American health problem. Not just American, but that's where we were living.

Early Human Population Laboratory Surveys; 1954 Smog Epidemic and 1960s Air Pollution Standards

Breslow: Now in California, to get back to the main thread here, we carried out a number of surveys of chronic illness in California. One of them happened to be very interesting. During the 1954 gubernatorial campaign when Goodie Knight was running against--

Morris: Dick Graves.

Breslow: Dick Graves. You remember, Goodie Knight had succeeded Warren into the governor's chair when Warren went to the Supreme Court, and Goodie Knight and Dick Graves were coming down to the wire in the next election; I remember Dick Graves was incapacitated by laryngitis during the campaign. But Goodie Knight had a problem in that we experienced during October of that year, the worst smog epidemic Los Angeles had ever suffered. The newspapers were just going wild over it. Knight attempted a number of rather foolish things, I thought, such as asking the oil refineries to close down and so forth, thinking that might stop the smog. It went on for two days, a week, two weeks.

It continued about three weeks, just a couple weeks before the election, and Knight had to do something. He called on the health department to answer the question for California, and the whole world, I suppose: When does smog become a killer? By that time, people were aware of what had happened in London, in the Meuse Valley in Belgium, in Donora, Pennsylvania--there had already been these

Breslow: smog episodes that kill people. Everybody knew it. And here we were having this worst smog ever in Los Angeles. It was a quite different kind of phenomenon, actually, from Donora or London or the Meuse Valley, but it was very exciting. People were very concerned about it.

So he asked this question of the health department. At that time in the Bureau of Chronic Diseases, I was asked to take on this study beginning the first of November of '54 and having a report ready by the first of March. Four months. To answer Goodie Knight's question--When does smog become a killer?

Well, you remember he won the election, in any event. I'm not sure what this had to do with it if anything, but--

Morris: Was that the first time you'd been able to do anything about smog?

Breslow: Well, yes, that's correct. During that period, we--

Morris: Didn't he give you some extra money to do this--?

Breslow: Yes, he did, that's correct. We also had help from the federal government and we assembled an advisory committee and we delivered a report. The first of March it was on his desk--printed! We didn't call it "Smog is a Killer." We called it "Clean Air for California." That was the name of the report. It was an analysis of the smog problem and recommended generally what should be done to handle the problem from a governmental standpoint.

Now what I wanted to tell you about was the survey work which was going on at that time--not to measure smog effects, but to measure chronic disease. But we were able to use, in a crude way, some of the survey results to bear on the question of whether people were suffering any adverse health effects from the smog. That's a whole other story, but I wanted to mention that we were then getting into health surveys.

This led, in the late 1950s, to a notion that is still being implemented, and that is a human population laboratory." We focused on Alameda County for a number of reasons. It's a typical county, it turns out, demographically; as typical as you could find in California and possibly in the nation, in those days. Look at demographic characteristics--almost whatever ones you want to pick--you'll find Alameda County is, not representative in the statistical sense, but it's typical. And it happened to be close to the health department headquarters.

Breslow: In any event, we got federal support, and that's another whole episode, to carry out studies in what we called Human Population Laboratory which were based on the survey method of assembling data about and pertaining to health.

Morris: Are you using data processing at this point?

Breslow: Yes.

Morris: Yes? Do the technological developments in going to computers--did they have an impact on what you were able to do and how you were able to do it?

Breslow: Now the job is easier, we can do it faster and to some extent, cheaper. You can make more complex analyses, but our instruments were designed not with respect to the kind of computer technology that's now available, because we were working in the early 1960s on this endeavor.

We spent five years developing our survey questionnaire and our methods of data collection--whether we could do as well by leaving questionnaires with people and having them returned by mail as by interviewing people personally. The latter was the presumed method of choice, but it turned out to be wrong. Our studies helped to correct that notion nationally--vs. the telephone--

Morris: It turned out to be just as well to send a questionnaire by mail as to send somebody to talk to them? I hope that doesn't make me obsolescent.

Breslow: No, I don't think it will. I think what you do is really quite different.

Morris: Did you consult with people whose business is polling?

Breslow: Yes. To recruit people for the Human Population Laboratory. The idea of doing a systematic, comprehensive study of health and the way people live as it is connected to their health and demographic characteristics, all of that could be obtained only by the survey method: sampling and getting information about each individual.

I looked around and said, "Gee, you know, we have to do this, but who are the people who can do it?" I found out the people who knew the most about it were those who belonged to the American Association of Public Opinion Research. They were meeting in upstate New York, some resort area. I think they meet there every year. And

Breslow: so I arrived there one weekend during their meeting time for recruitment. I didn't know anybody. I just went there and wandered around. They really had some great parties [laughs], I remember that.

In any event, I met some people who had been trained by Paul Lazarsfeld, whose name I recognized. He had done the theoretical work underlying survey sampling studies. And I recruited some of them. One of them is a particularly key figure--Joseph Hochstim whose eightieth birthday we celebrated just a week ago in Berkeley, along with the celebration of the twenty-fifth anniversary of the Human Population Laboratory which we started in 1959. We did the first comprehensive survey in Alameda County in 1965. Before that, we'd done a number of preliminary surveys following up on our statewide surveys in the fifties that I described to you. So a great deal of attention was focused on this survey approach to measurement of chronic illness, to measurement of health, to studying ways of living and health.

About this time, in 1960, I was appointed to be the head of the Division of Preventive Medical Services succeeding Bob Dyar who became the head of another division in the department. So I had a large administrative task which embraced all of the several medical bureaus; acute communicable disease, chronic disease, crippled children, maternal and child health; all of these and others. I moved into a more active administrative responsibility but still tried to keep up with the research endeavors that I have just been describing to you: the Human Population Laboratory, and other health survey work.

The air pollution work was rather interesting. I mentioned to you earlier the smog episode in 1954 and how we got into that. Our first report really set the line for the development of air pollution control work in the country. Even the words we used--Clean Air for California--have been adopted very largely for this kind of public health work.

After Goodie Knight's venture into the field, not much happened through the rest of the fifties, until Pat Brown was elected. He came into office, when, 1959?

Morris: He was elected in '58 and entered office then in January 1959.

Breslow: Fifty-nine. Okay. He brought in with him, you may recall, Warren Christopher.

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Breslow: He has had a great career in many respects since and is still in his heyday, I suppose you would say. Warren Christopher was one of several very bright young attorneys that Pat Brown brought in with him to get the new administration started. Christopher didn't intend to stay as a permanent fixture in state government and he did not.

One of his assignments, however, was to look into the smog business. He did so without talking to any of us in the department to begin with. But a few months after he arrived in Sacramento, he came down to the department and asked to see me and a colleague in the department, John Maga. John Maga was then in environmental health work under Frank Stead and I was just moving into the Division of Preventive Medical Services. I don't know how Christopher got my name but he came into the department from the governor's office and obviously he could see anybody he wanted.

Morris: He came to see you, though; he didn't holler over the phone and say, "Come talk to me."

Breslow: Oh, no. He came down to the department. I didn't know him except that I'd seen his name in the newspaper once or twice. He announced that he had been looking into the smog problem and that the governor now wanted the department to do two things: one was to set standards for ambient air, that is, how much of this stuff should be tolerated in the air that people must breathe. He knew enough to specify a few things like the amount of ozone and particulate matter and so forth, that's what he indicated he wanted measured. The second assignment was to specify standards (both of these were specifying standards), the second one, for automobile exhaust--to minimize the smog. We were going to obtain a certain degree of cleanliness of the air. To do that from a scientific standpoint, we knew, the approach was to control the exhaust from automobiles. It didn't come to any great extent from the refineries or other sources, in California. It came from automobile exhaust almost entirely. That had been found in studies somewhat under the sponsorship of the department but principally under the leadership of a man at Cal Tech--Haagensmit.

Well, John Maga and I looked at each other and more or less answered Christopher that he must be from outer space. That idea was just off the wall. It was an impossible task, and so on and so forth.

Breslow: Christopher said that he didn't care for any of those responses. He would just be interested to know what we did about the assignment to set standards for ambient air and automobile exhaust. [laughs] We have since become quite good friends. But I thought then, my God, that guy is out of his mind!

But then John and I began to talk about it and thought, well, maybe it's not impossible. We can't do it perfectly and to satisfy scientific criticism for the next fifty years, but maybe we can get a good start on it.

Morris: And was Christopher's idea that this should go into legislation or was the Department of Public Health just going to implement these?

Breslow: There was going to be legislation and the department was going to establish the standards. Oh, yes, there was going to be legislation, he was just telling us that we were going to have to do the technical job. He was just letting us know. They were going to pass legislation, we were going to do the job.

So we began digging into it pretty fast and furiously and we decided that, by gosh, it could be done. So we prepared these standards and took them to the (then) State Board of Health in 1960, thereabout. We brought the standards for ambient air and for automobile exhaust to the State Board of Health for public hearing. The oil and automobile industries, of course, were intensely interested in the matter. They had assembled experts to look over our shoulder, work on committees, and they knew everything that was going on, which we were happy to have them do.

Morris: You had already been through this with another environmental concern, water quality standards.

Breslow: That's right. Frank Stead may have told you about that.* We went through it again with air pollution standards, proposed these standards to the State Board of Health, the staff speaking to the Board of Health. When the board asked for responses from interested parties, there was nothing to say. We had really done the job. So these standards were adopted and thereby California was the first place in the country to adopt such standards. Then gradually other parts of the country have adopted and now you know the conflict, back and forth, who's got the best standards and what's the best

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*See interview with Frank M. Stead, "Environmental Pollution Control," in Earl Warren and the State Department of Public Health, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1973.

Breslow: justification and so forth. But the basic idea came from Warren Christopher and Pat Brown's staff, and we in the department had the technical job of go-do-it.

Morris: Putting it into operation.

Breslow: Yes, that was quite an interesting episode.

Contacts with Pat Brown as S.F. District Attorney

Morris: Could you take about two minutes and tell me about Pat Brown's interest and yours in public response to alcoholism? You said you'd worked with him on that when he was San Francisco district attorney.

Breslow: That's right, before he was attorney general, he was a San Francisco district attorney. And there, somehow, he became interested in the police handling of alcoholics and their handling in the entire legal system. Being a very humane man, he felt that there ought to be a better way of dealing with this problem and so he was trying to find out how health people: doctors, hospitals, public health people, viewed the problem. What was the problem as they saw it. I came into contact with him personally during those years.

I recall one little episode with him, when he was running for state attorney general. I had already worked with him some, as I say, locally, on the problem of alcoholism. He was scheduled to be in Berkeley at some kind of campaign party--a lawn party one Sunday afternoon at the home of a well-renown Republican; it was obviously to attract Republicans who might support him.

Morris: He ran for attorney general as sort of non-partisan.

Breslow: In any event, one of my sons (he was just a kid, ten or twelve years old, something like that, said, "Gee, Mr. Brown," (I'd apparently mentioned him previously) "is going to be in Berkeley. I'd like to meet him. You say you know him." So I gulped, and thought, my God, how will Brown ever recognize me, how did this happen? Okay, my son wants to go. So we went over to this party and here was a big long line of people going by Pat Brown, shaking hands, as you do in such receptions. When I got up to Brown I was about to remind him who I was and what our relationship was.

"Doctor! I'm so glad to see you here." Then he leaned over and whispered to me, "What are you doing here?"

Breslow: And I said, "I came here with my son."

He and I have had a very warm relationship, not terribly close or intimate; but he is a marvelous man. I also had an interest in something that he and Earl Warren were close on: Even though they were in different political parties, they had many of the same humane instincts and even political ideas and social ideas.

Earl Warren, the California Medical Association, and Health Insurance

Breslow: If I can jump back a minute, Earl Warren had a notion in the late 1940s to develop state health insurance. He had several children and some heavy medical bills for his family; he saw what was happening to people and so, quite sharply different from Republican ideology elsewhere, Warren decided to espouse state health insurance. If they weren't going to do it nationally, we'd do it in California.

Well, to do that, he needed to have a little technical assistance in writing his speeches and so forth. So he called on his state health director, Wilton Halverson. Halverson would have absolutely nothing to do with it.

Morris: Really? Because he saw it as political?

Breslow: He thought it was the wrong thing to do, and it was going to interfere with public health work, especially alienate the medical profession, and it wasn't right in any possible way.

Morris: Health insurance?

Breslow: State health insurance. And as far as the health department was concerned, Halverson was going to have nothing to do with it. That was very clear. It wasn't public, but it was very clear. So Warren looked around, I don't know how he did this; but he picked me out. One day I got an invitation to come up and work in Sacramento. It turned out I was to work on some of Warren's speeches. So I got involved in the late forties in writing some of Warren's speeches on health insurance. He had real speech writers, you know, I didn't write the final speeches themselves, but I contributed ideas and--

Morris: Putting the details in. I think we have some of the finished product in our files.

Breslow: Well, I'd like to look at those someday.

Morris: All right.

Breslow: To see if I recollect anything. But there was a humorous part of this, I must tell you. Sorry to be so distracting, but you know, the privilege--

Morris: No, these are interesting days. These ideas keep coming up again.

Breslow: When we started the cancer-control work, as I told you, in late 1946, I looked around the country and decided the first thing to do was to start a tumor registry. We wanted to get all the cases of cancer from a hospital, and then maybe from a county, and so forth reported to the state so we could get some notion of the problem. That was always my desire--to get some grasp of the problem. How many, who gets it, and so on. What kind of cancer, how far advanced, and how did they survive? So I worked out with the (then) cancer commission of the California Medical Association a proposal to develop this tumor registry. I had a date to meet with the cancer commission at Jack's Restaurant in San Francisco in the spring of '47, having worked it out with the chairman, a man named Lyle Kenney from San Diego. And the people of this commission were the powers in the California Medical Association: surgeons, radiologists, pathologists--they were the big specialties. The leaders of the whole medical profession were in that cancer commission, it happened. John Cline, for example, who went on to become the president of the California, then the American Medical Association, and some others.*

Well, on my way, literally on the corner, walking up that street to Jack's Restaurant, I saw a headline in the newspaper--"Governor Warren Introduces State Health Insurance Bill." I got to the restaurant (they had a private room there) and those men were literally fit to be tied. I'd never seen such an angry, vituperative, outraged group of mature men, all physicians. They really assumed that I was a part of this enterprise in the cancer registry.

Morris: That you had come to ask them to support Warren's legislation?

Breslow: No. They knew that I was there only to get the registration of the cancer patients, but you see how it was linked in their minds--the state was going to get hold of the names of the cancer patients and then somehow develop a state service to take care of cancer patients!

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*See interview with John W. Cline, "California Medical Association Crusade Against Compulsory State Health Insurance," in Earl Warren and Health Insurance, Regional Oral History Office, The Bancroft Library, Univeristy of California, Berkeley, 1971.

Breslow: I mean, it was just an insane idea! No one would have thought of this way of starting a state medical insurance program. In Massachusetts, and Missouri, a couple of other places, decades before, they had started so-called state cancer hospitals, but that was quite a deliberate thing, quite unconnected with the registration of cases. The fact that you get reports on diptheria or smallpox doesn't mean you're going to be providing medical care for them, you know, you just want to study what's happening.

They were so angry that we could not talk about the proposition to establish a tumor registry. I didn't even stay for a dinner. As I was leaving, Lyle Kenney, the chairman, who was quite a wise man, put his arm around me.

"Lester," he said, "don't feel too bad. I realize this is just a coincidence, but you see the way they feel about it. So, we'll put this off for this meeting. In another three months or six months, come back, we'll revise the plan some, and by that time things will have cooled off. This bill isn't going anywhere, anyway. And we'll start the tumor registry later."

So that's what happened.

II MAINSTREAM MEDICAL CARE FOR THE POOR

Public Health Movement for National Legislation

Morris: So you had a fair amount of experience with the different parts of the community interested in public health-- Then the federal health care legislation came along about the time that Dr. Merrill was ready to leave the department?

Breslow: That's right. And of course, Pat Brown did then appoint me to be the director. But before that time, even, we got into some other matters such as the Medi-Cal, but maybe we want to talk about that later.

Morris: From what you were describing earlier, it sounds as if the State Department of Public Health would not have been involved in urging the passage of this federal legislation. Is that right?

Breslow: That's correct. Neither Halverson nor Merrill were interested in what the American Public Health Association was already doing, namely moving towards support of national legislation for health care of some kind. It took the form ultimately in 1965 of the Social Security Act changes--the passage of Medicare and Medicaid. That was before I was director but during the period I was head of the Division of Preventive Medical Services, during the early part of the 1960s--'60 to '65.

But I was interested in matters of medical care. I was involved not only in air pollution, preserving quality in the crippled-children's services program, in measurement of health by the survey method, and in the development of the human population laboratory. Another interest of mine that was quite widely known, certainly no secret, was medical care. I was one of those in the American Public Health Association that was very eager to see public health take the lead in doing something

Breslow: about medical care in this country. Not because I was a medical economist or anything of the sort or had any personal interest in medical-care administration--running a hospital or a medical program, but because I saw it as a means of advancing health. Medical care could do something for health. I was already coming to the notion that it couldn't do as much as we could do by promotion of health, as we defined it in the report in the President's Commission, but medical care could do something and something quite substantial. Therefore, since it was going to do something for health, we in public health ought to be doing something about making it more generally available and of better quality to the people who needed it.

Well, that was my attitude and that drew me into contact with welfare people, and people like Warren and Pat Brown who had similar ideas. It also brought me in touch with people nationally in the American Public Health Association who had these same ideas and in various committees of the American Public Health Association.

Morris: Was your survey work turning up some data on--?

Breslow: Relatively little. Our survey work was much more directed towards health rather than towards medical care. We were really trying to find out about health, the demographic features of people and their ways of living that affected health.

Morris: Not the medical aspects--

Breslow: Not the medical care, not the medical aspects. We included some questions on that, but our effort was differently focused. But quite apart from all of that, I'm trying to convey that I had an independent interest in medical care. So when you ask about my relationship to the national medical-care movement, so far as I was concerned, it was a personal venture. It had nothing to do with the department. And I was not representing the department in that effort at all. I did represent the department in other things, air pollution and so forth. Medical care--that was a private, professional view. And Halverson and Merrill, too, made it quite clear that it better be personal.

Morris: It should not be expressed as a department view.

Breslow: So when you ask what did we do about the national legislation, all I can tell you is that I was a strong supporter of the Medicare legislation as it developed, as was the American Public Health Association as a whole. But the leadership of the California Department of Public Health, being more conservative, and having done some very good things which I was proud to be a part of, still was not going to support this legislation and in fact was a little opposed

Breslow: to it, I guess. Merrill was more circumspect in his attitude and, of course, Halverson was by that time gone. Halverson had been quite outspoken on the opposite side although he was a very humane man. He just didn't feel that this was the way to go at the problem.

Testifying Before Congress on Nursing Homes

Breslow: I got drawn into some of the planning and testifying on the national scene. I recall one point, for example, which we had mentioned in the commission report in 1952: that nursing homes, ideally, should be connected with hospitals. We said in the commission report--I learned a lot during that period; it served me well for many years. I wish every person in public health would have such an opportunity.

We said in this 1952 report, "In general, bringing nursing homes into close administrative, professional, and geographical affiliation with general or mental hospitals would seem to offer the best prospects for improving the quality of nursing home care."*

When it became apparent that nursing-home care was to be incorporated as a benefit of the Medicare program, I became very interested, among other reasons, because it had to do with chronic disease more than some other features of the Medicare legislation. So I jumped into that.

Morris: And you testified in Washington?

Breslow: I recall there were two things I did on that matter. One was to review the budget for nursing-home care that was proposed for the original Medicare legislation. It was based upon a very limited experience of Blue Cross with nursing homes in New Jersey, and from that projected a national figure. I was astonished when I saw what they had done. I figured out that for the first year's budget, the total item for nursing-home care nationally would be spent in California. Because they simply hadn't made an appropriate projection of this very limited experience. So I wrote to them and told them about it and told them, "My gosh, don't do this, it will be terrible. You have to increase that budget by at least ten-fold."

"Oh, we can't do that, because that upsets the credibility of the whole estimation process. So for heaven's sake, don't talk about that."

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*Op. cit., p. 27.

Breslow: I got into a really tough argument on that matter with Wilbur Cohen, then secretary of HEW, who was defending the estimates that had been made for the Medicare legislation. And then I raised another issue. I said, "Well, you're going to be wrong on dollars, but I guess that gets adjusted afterwards; but you really have to be concerned about the quality. That's really important. So, for heaven's sake, require that nursing homes be professionally, geographically, administratively affiliated with good general hospitals. That's the way to preserve and improve the quality of nursing-home care.

"Hospital care is enough of a task and we don't have good enough methods of quality control for them, but for nursing-home care, we've got nothing to preserve standards. Oh, we have licensure, to see if there are rats running around the place or if the electric wiring is exposed or something like that. But for quality of care, here you have a marvelous opportunity to assure, as best we can in American medicine, the quality of care in nursing homes." Well, for various political reasons, I guess, I don't know what other reasons, that idea was not adopted.

And I went to Washington to testify on that point. I remember Phil Lee--Russ Lee's son. Phil Lee was the assistant secretary for health then. And at the hearing, he sat between Wilbur and myself. Wilbur was on the left and I was on the right, I remember, and at one point the argument got so intense that Phil had to put his arms up [laughter].

Morris: To keep both of you--

Breslow: Well, to get back in our chairs. It seems funny now, but I was pretty intense about the matter. I think a terrible mistake was made and a great opportunity was lost.

I didn't have a lot to do with Medicare. I supported the whole thing, of course, and testified for it in various ways, but this specific point was the one that I felt they had a great opportunity to really do something about. I couldn't see that nursing homes were then in a sufficiently strong political position to resist. They had some strength, but after they got to paying them hundreds of millions of dollars, there was going to be no way you could put the thing back in the box. A proper standard for quality could have been set, but we lost that great opportunity.

Morris: Did you have the sense that there were similar situations with the estimates and projections in some of the other sections of the legislation?

Breslow: I never did much work on those. But nursing-home care was something I was interested in and knew something about.

Morris: Right. Something the Department of Public Health had a role in.

Breslow: Yes. We'd been doing studies.

Morris: Tell me more about the Medi-Cal part of it.

Breslow: Well, then perhaps we ought to move to my being in the office of director, which came about in 1965. That was just the year that the federal legislation was passed. So while they were thinking how California would respond to this (you recall that it was quite clear throughout that the Medicare program was going to be a federally administered program)--

Morris: But there was a separate title of the same bill.

Breslow: Medicaid came along, but that was added only at the last minute.* There had been discussions and so on, but it was a compromise with the AMA. Not too surprisingly, the AMA bitterly opposed the Medicare part, but supported the Medicaid amendment. And one of the reasons the bill passed, naturally, was that the AMA was quieted down, bought off, whatever word you want to use, by having Medicaid passed, but it was to be a state-administered program for the poor.

When that became apparent, then, in California, we began to pay some attention to that. But it happened so fast, at the very end of passage of the legislation, that we really didn't begin to think about it until the legislation passed.

Appointment as Director of the State Department of Public Health, 1965

Breslow: About that time, I became director of Public Health, in '65. Paul Ward was then the secretary of the Health and Welfare Agency and my boss within state government--between the director of Public Health and the governor, Pat Brown.

Morris: There was already Paul Ward as the main agency administrator when you became director of Public Health?

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*As Title XIX of the Social Security Act of 1965.

Breslow: Yes. I'm not sure it was officially an agency, but I think it was. It was made one about that time.

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Morris: Was it because of your interest in the Medicare/Medicaid legislation that they would have recruited you as director of Public Health?

Breslow: I doubt very much that had much, if anything, to do with it. My perception is that my appointment was probably due to two main factors. One is that I had been in the department for nineteen years, was in that tradition, had been given a high office within the department by Merrill, had been highly regarded before then by Halverson (after we got acquainted). So that was one point: it was maintaining the tradition and the notion of competence in the health department--and there was respect for that.

The other element, perhaps, was what you might call an ideological or social one. Brown and his administration knew that I was sympathetic to their administration, supportive of their administration. I suppose it was those two elements rather than anything to do specifically with Medi-Cal, because we hardly knew how that was going to work out.

Morris: There were other people in the department who had been there a while too. Was there any sense that the governor had to make a choice between two or three of you senior division chiefs?

Breslow: I really don't know how it happened. It had always been a physician, trained in public health, experienced in public health administration. Another person who might have been appointed would have been Dyar, who had been my predecessor in the office that I was then holding--the chief of the Division of Preventive Medical Services. Conceivably, it could have been one of the medical bureau chiefs. Or anybody. But I never thought about it as a competitive thing.

Morris: Competitive wasn't so much what I was thinking of as, in general, talking to governors about appointments, they speak about being besieged by applicants from partisans for this person or that person in department jobs.

Breslow: I know something about that with respect to the next governor. Toward the end of my term as director, 31 December 1967, some anti-public health, conservative medical elements--especially from Bakersfield--lobbied the governor's office heavily against my reappointment; probably no lobbying was really necessary.

Breslow: With respect to Pat Brown's appointment of me, however, I wasn't ever conscious that there was any competition or politicking. I was frankly surprised to be appointed but very pleased. Then immediately thought, "Well, this is the most natural thing in the world."

Morris: Did Pat talk to you about it or was it Paul Ward?

Breslow: I don't even remember.

Morris: It sounds like it was sort of just a routine thing once the--

Breslow: I suppose it was Paul Ward, just because of the general way we worked in those days. I would have to think it was Paul Ward because Brown did operate in quite a proper administrative fashion. This was in Paul Ward's jurisdiction, so I presume he would have had Paul Ward do it, but I literally cannot remember.

Morris: Or maybe someone of the aides in the governor's office?

Breslow: No. I'm sure it went through his office, but I never personally had much to do with--

Medi-Cal Legislation: Implementing Federal Medicaid in California

Morris: Did you expect this upcoming Medi-Cal program to be a major part of the things that you wanted to do?

Breslow: Oh, yes! When the legislation passed, we entered into very intense discussions about the implementation in California. Those were principally discussions between Paul Ward and myself.

By that time, of course, we'd had quite a bit of personal contact--even before I'd become director, because they had learned to turn to me--Ward did and Pat Brown did--on what they might have regarded as political things. They knew that the prior directors, Halverson and Merrill, wanted to steer clear of any of that, and so they just thought, well, who's somebody else down there that we can turn to? Who seems to be technically competent but who understands and is sympathetic with our political aims. It was never discussed as political, but this just happened.

So when this came along, Paul Ward and I had a lot of talks. Other people were involved--we brought in various experts--but Paul turned to us, and to me in particular, to help formulate the Medi-Cal

Breslow: legislation. Actually, my participation was in three directions: One was, and Paul just very recently reminded me of this, that in the discussion, my role was to advance key ideas. I did not have anything to do with writing the bill. Oh, I might have looked at it or written a paragraph here or there, but Paul did that himself. He had other experts working with him, but Paul was really a master legislation writer.

Morris: How come? Was he an attorney by trade?

Breslow: No, he (what is he?). Let's see. He'd worked as an aide to a legislator, to George Miller [Jr.], going a way back, then he had worked in welfare administration. I forget his total history.

But in any event, Paul reminded me recently that the principal idea that I pushed for was comprehensive care. That instead of having the program pay just for limited hospital care--so many days in a hospital and so much physician care--that we really should go all out and provide dental, mental, drug; the works. And the argument that I advanced was that, look,the federal government was going to pay 50 percent of the bill. And look at all these benefits we were getting for Californians who needed it, for half price.

That was the argument which I advanced and Paul bought that, and evidently that is the reason that California's original Medi-Cal legislation was so comprehensive. You may know that the states could each decide, within a certain limit. The lower limit was mandatory--they had to have certain things to qualify--but after that, it wasn't quite the sky's the limit, but New York State and California both adopted the stance that I advocated here. Namely--

Morris: You get double whatever you put into it.

Breslow: Exactly. Now they call it leverage. In those days I didn't know the word.

The second point which I was very interested in was quality of care. We'd had great experience with the crippled children's services where we provided quite a wide range of services by this time for youngsters who had not only grossly crippling conditions, poliomyelitis or things of that sort, but also individuals with congenital heart disease and with various other diseases that were not so physically obvious. We had maintained and built up principally under the leadership of Dr. Marcia Hays, whom I mentioned earlier. And this was carried forward by Dr. [Charles] Gardipee and others in the department.

Breslow: In any event, we had a very good program, one of the best in the country, that Marcia Hays had developed. One feature of it that was intriguing was that she had worked out with the medical profession, advisors who were expert in the various features of the work, the hospitals, even the doctors, by whom and where the best care was available. The state paid for that. It paid good money, but it got the best service. In the long run, that's the cheapest. And the program flourished. And so I pleaded with Paul.

I said, "I realize we can't do this the whole way, but for heaven's sake, let's get started to do something to maintain not just a comprehensive array of benefits, but also the quality of the benefits. I'm not entirely sure how to do this, but here are some ideas."

Paul had to take the thing politically.

Morris: Was there a third point?

Breslow: Yes, there was a third point. On this point, the quality, however, Paul adopted the notion that the whole political theme was to obtain mainstream medical care for the poor, instead of confining them, largely, to the county hospitals in California. They were going to be given the option of going to any doctor, any hospital. And those doctors and hospitals would be paid, so that the people would have access to medical care like anybody else.

Paul took the attitude, "We can't do anything special about quality. We license doctors, we license hospitals, everybody else is getting care from these same places and people, and that's mainstream care and that's what we have to have."

Budget and Administration Discussions; Office of Health Care Services Established

Breslow: The third point that I advanced--I lost on that second one--the other point that I was involved in was the budget. I participated quite fully in preparing the budget for the first sixteen months of Medi-Cal.

Morris: And the first budget was a sixteen-month budget?

Breslow: It started the first of March. We wanted to get in. I said, "Paul, let's go. Every day we lose a lot of money from the federal government. Let's get the program in here."

Breslow: And he persuaded the legislature of the same thing, so we started the first of March, 1966. And the budget was prepared for the next sixteen months.

Morris: Until July, 1967?

Breslow: Until July, 1967. That would be six months into the term of the new governor if Brown were not re-elected, which he wasn't. And again, we were talking recently, and Paul concurred that the budget estimate which we made for those sixteen months was remarkably on target. Very close to the mark. Now, of course, this was a new program and many new agencies, hospitals, nursing homes, physicians and so on were getting into it and submitting bills so there was still quite a bit in the pipeline; but that would be true, and we anticipated that would be true, any year we started. You know, you're always getting bills in August for what was done in April, May, or whenever. So as far as the actual budget is concerned, I don't have the numbers, I think if you go back and look at it, you'll find that it was remarkably close to what was actually spent.

Morris: I came across a figure, what was it, $805,000,000?

Breslow: That may be right, the total budget the first sixteen months. And half of that was federal and half state, if I recall correctly, is that right?

Morris: That was my question. I didn't know if $805,000,000 was the total or if that was the state half.

Breslow: I think that must have been the total budget. I think the state may have put a little more than half in, because there were certain things that we said we'd put in even though the federal government wasn't going to match.

Morris: Like what?

Breslow: I don't recall the details now, I'd have to go back and look at records that aren't available to me now. I'm not sure what that amounted to, but it wasn't very much.

Then, after the legislation was passed and the budget prepared, the decision had to be made, who would administer the program. There were two obvious possibilities. One was the health department, and from a technical standpoint and interest I was heavily engaged. By then, I was the director of the department--this was March of '66. So I proposed that it be the health department. The welfare department was also a possibility.

Morris: To what extent had they been involved in developing the--?

Breslow: They had been involved to a considerable extent also, in defining the population, in working out with the counties how the eligibles would be determined. So they were concerned more with the population side of it, and we were concerned (and I took a very active role in this, even though I was the director of health) in the comprehensiveness of the services, the quality of the services, and the budgeting for the services. But Paul essentially wrote the bill.

Morris: How about the people in the Department of Finance? Did they get involved in the--

Breslow: They were out of their element. Of course they were involved, but they had only been involved in Public Assistance Medical Care and the very limited nature of those things which we were paying for, very limited things for a very few people. And budgeting for this whole population of Medi-Cal eligibles and for these comprehensive services was a pretty bold undertaking. They were very closely working with and criticizing and looking at what we were doing, but I think it's fair to say that we took the lead in preparing the budget. Other people might give you a different story from a different perspective, but--

Morris: I'm just trying to piece together how it worked.

Breslow: Well, the Department of Finance was, of course, very interested. Four hundred million dollars, in those days especially, was a big amount of money. They were very interested and obviously the governor wanted to have them closely involved.

Morris: In drawing up this first sixteen-months budget, did you spend any time on projecting out how that sixteen-month budget might transfer into year two, year three, year four: what was likely to happen as you got experienced with the program in California?

Breslow: In all candor, I don't believe that we devoted a great deal of attention to that. Our notion, rather, was that here was this federal support for the first time, really, to match what California could well afford to pay for important services: health/life preserving services for people for whom the state had responsibility. And we wanted to make the best possible program. Yes, it was going to cost quite a bit; but we did not try to project fully what it might be in the fourth, tenth year and so forth. I presume the Department of Finance tried to do that.

Morris: Was Pat committed to getting this enacted and in place in California, or did the federal law say, "Each state shall have a--"?

Breslow: No. It's purely option. As a matter of fact, for many, many years, Arizona declined to participate. Only very recently did that state come into the program. And other states came in somewhat later than we did. We were among the very first states.

Morris: Weren't there some California congressmen who had been in the legislature who were involved in all this?

Breslow: There may well have been. I don't recall.

Morris: Were the congressmen and the legislators involved in the process of setting it up?

Breslow: Of course. Paul dealt with the legislators. I had, oh, I knew them occasionally, and would maybe be called up to testify on technical matters, but all of that was handled by Paul Ward and out of his office. Remember, I was in Berkeley in the health department in those days, and this was all going on in Sacramento. I'd travel up there, occasionally Paul would come down to the department in Berkeley; but the lobbying, if you will, was all done by or under the direction of Paul Ward.

Morris: That sounds like that might have been a good reason to have an agency administrator as an intermediary.

Breslow: What happened was that neither the health department nor the welfare department came out as the administrators. Instead, there was established an Office of Health Care Services in the agency office. That is directly under Paul Ward.

Now, the reason Public Health did not get it, I believe, and have quite good basis for this belief, was manifold. Paul Ward was inclined to give it to us. He had respect for our technical competence and knew that we would do a careful, good job as we had done in other programs, even though this was mammoth compared to anything else we had had, from a budgetary standpoint.

He was worried, however, that giving this program to us would wash out other Public Health programs; that it would so overwhelm the department that the other good things that we were doing might have been neglected. That's a very common view, by the way, in the discussion on why public health and medical care should be separated. As a matter of fact, a great number of public health administrators adopt that point of view. Halverson did, Merrill did--that was their

Breslow: view. "Look, our job is public health. If we take on this mammoth medical-care job, then any money we have for crippled children or maternal and child health or communicable diseases control or environmental health or laboratory--whatever--it's going to be wiped out. We'll be looking for every dollar to pay for medical care. Let's stay out of it."

Well, Paul recognized this as an argument, and so, while he was inclined this way, he wasn't committed to making it a Department of Public Health endeavor.

The second and more important reason was that the Senate Finance Committee, which really was the critical committee in deciding on the program, was certain against Social Welfare having it. They didn't care for the Department of Social Welfare. And they were persuaded not to have it in Public Health because the California Medical Association had an armlock on the Senate Finance Committee politically, and the California Medical Association didn't want to have us in Public Health involved.

Morris: Really? Why not?

Breslow: Why not? Because they knew how we operated with respect to licensure of hospitals, how we operated with respect to the crippled-children's services. They knew that our attitude was that medical care was not just some kind of service people were entitled to and that some people provided and got paid for, but that we viewed medical care as some means of advancing public health. We looked upon it the same way we looked upon air pollution-control standards or crippled-children's services or pre-natal care where very careful standards were worked out. They were not irrational standards--they had to acknowledge that they were the best that could be obtained--but they knew that we really believed in standards and would probably be doing something to enforce the standards. And they didn't want any of that. They wanted to have this open basket so that their members as well as other providers could come and pick out of it.

Morris: Had the CMA representatives been part of the consultation process in developing the legislation and then the budget?

Breslow: Oh, yes, they were involved, and particularly a man named Ralph Teal who was from Sacramento and then, or shortly thereafter, president of the California Medical Association. He was dead set against the health department and generally that was the attitude.

Morris: Is he any relation to Steven Teale?

Breslow: No. The name was spelled differently. Steve Teale was T-E-A-L-E. Steve was also a physician--osteophathic physician and I don't recall Steve's position on the issue, but Ralph Teal was not in the legislature as Steve was. Ralph Teal was a medical--

Morris: Right. A representative of the CMA.

Breslow: That's right.

Morris: An employee of the CMA?

Breslow: No. He was a practicing physician and a leader in Sacramento medicine and president of the CMA either at that time or just about that time. And he was adamantly opposed to Public Health having anything to do with it. He was a person very much like another physician of those days, Jim McLaughlin, a San Diego pediatrician, not board certified but active in California Medical Association politics, who fought us for I don't know how many years on the crippled-children's services standards. We insisted that only physicians who were competent, in hospitals and with appropriate teams, should provide service for children who for the most part, needed very expert care. It wasn't like caring for a child with a runny nose, you know, or the chicken pox. These were really serious cases. And McLaughlin, who was not board certified--

Morris: Had not passed the national pediatricians' board?

Breslow: That's right, and a practicing pediatrician, tried for ever and ever to break down that cripped-children's services standard of care. And Teal, Ralph Teal, was of the same political mold: that we should have no standards set other than that a licensed physician should provide the care.

We did not announce--of course, there was no occasion for us to announce what we would do if given the responsibility for Medi-Cal--I'll tell you in a moment the way we did approach the problem of quality.

Morris: What was the solution to there being reasons not to give the program to Social Welfare and not to Public Health? Who was selected to--

Breslow: They set up a new Office of Health Care Services in Paul Ward's office.

Morris: In Paul Ward's office. And bring in somebody new to run it?

Breslow: He brought in somebody from Welfare at first to do it, but that was as an administrator. He did not bring in a public health person to do it.

Morris: The first name that I find in the rosters is Carel Mulder.

Breslow: Mulder, that's correct. It was Carel Mulder.

Morris: Now, was he a physician?

Breslow: No, Carel Mulder had been in the Department of Social Welfare. He was the person to whom I was referring. He was a welfare man through and through.

Morris: That denotes--?

Breslow: That denotes that he was committed to providing services to people in need, that he had been brought up in and adhered to the welfare approach, but he was completely unsophisticated in medicine or medical care or health matters. He had no more than a layman's knowledge of it, and he obviously was given to understand that he was to run it and that Public Health was not to "interfere."

Morris: I see. So that must have been sort of an awkward situation for everybody concerned.

Breslow: Oh, not awkward at all, why awkward? I was upset, but so what; I sometimes got upset about other things.

Records Management; Medi-Cal Use and Abuse

Morris: And you, having done all this work on the preliminary, you just went on with other things?

Breslow: Oh, I had lots of other interesting things to do that I'd like to tell you about, but quickly, on this, what we did was to persuade Paul Ward (there was no use dealing with Carel Mulder) that we needed to have adequate records on Medi-Cal in order to know what was happening. He agreed, and Henry Anderson put that together.

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Morris: So Henry Anderson designed the records system?*

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*Mr. Anderson headed the Department of Public Health Medi-Cal Surveillance Unit, which conducted its survey on contract to the California Health and Welfare Agency.

Breslow: Well, he did an analysis of some of the records. We had a substantial part in assuring that such records would be available. But he undertook the real work of assembling and analysing these records. And the records permitted this to be done: the identification of the physician or, in some instances, they were groups of physicians who had one billing number--that is, a small number might practice together and they would submit one bill--the identification of those physician providers; and the number of Medi-Cal patients whom they saw over a given period of time.

Morris: So we're talking now about the statistics from that first sixteen months?

Breslow: Yes. It was, I think, the first complete year after the first four months, but I'm not certain. This paper has been published in the American Journal of Public Health, and I guess I should have gotten it out.*

Morris: Knowing it's there is fine.

Breslow: American Journal of Public Health, published in probably '68 or thereabouts. The author was Henry Anderson.

So we could identify the physicians or small groups of physicians that provided the care. Second, we could identify for each of these, not only the number of patients that they saw, but the number of certain kinds of services that they provided. For example, the number of injections that they would give, and even the number of injections apart from immunizations and apart from treatment for allergy, which are rather specific things. But apart from those, all other injections.

Then we could divide the physicans into those that saw no Medi-Cal patients or very few Medi-Cal patients and those who saw a substantial number--say over fifty in a month or over a hundred a month, or whatever group you wanted to analyze. There would have to be a sufficient number of physicians who were seeing a large number of patients to prepare a ratio of the number of injections per hundred patients. So we could identify a group of physicians or a particular physicians, and say he saw a hundred patients and he gave ten shots/injections for which he charged. And there's another physician who saw a hundred patients and he gave two shots. And there's one who saw a hundred patients and he gave fifteen shots, and so forth. Then

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*"Statistical Surveillance of a Title XIX Program," American Journal of Public Health, 59, no. 2, February 1969. See Appendix A.

Breslow: Then we could look at the distribution. We could look at all the physicians who have a ratio of, for example, ten or fewer, or fifty or more, shots per hundred. I have asked physicians in practice, good physicians--and I've done this dozens of times--what would be a proper ratio? Practices differ and some people see children more and some see adults, and some see many elderly patients.

Morris: And some see patients with allergies.

Breslow: Well, putting allergies and immunizations aside, what would be a reasonable ratio? And most physicians say, well, ten, five, fifteen, something like that.

Actually we identified some physicians who had twenty-five shots per hundred. This consistently over a whole year. And some who had fifty or more, seventy-five per hundred or more. We found some whose ratio was more than a hundred to a hundred patients. There weren't many, but there were a few.

From such an array of data, we noted, you can quantitatively define, as you choose, and determine who is "a shot doctor." Almost everybody who comes by may get a shot. Extra payment, of course, if you get a shot.

So you begin to define the so-called Medi-Cal mills--individual physicians.

Morris: As soon as the first year.

Breslow: As soon as the first year. Seeing these data, I took them to Paul Ward and said, "Aren't these interesting? Don't you think we ought to do something about these? Now, where do you want to cut off?" I said, "It's just like in licensing hospitals, as I see it. Maybe the way to proceed is from the bottom. Start at the very bottom and gradually proceed upward to some reasonable level. Even if we took the physicians who are giving seventy-five or fifty shots per hundred patients, you would get quite general concurrence that they ought to be investigated, at least."

Morris: That that's not good medical practice?

Breslow: Probably not good medical practice. We pointed out to Paul that you cannot take any such statistical indicator and declare someone guilty. I want to give you an example of why you can't do that. We did some other ratios, such as the number of home-care visits to all visits. In those days, physicians, some of them, were still making

Breslow: home visits. So we did the same thing with that--we did a lot of these ratios. I just gave you the most outstanding and perhaps the easiest to understand.

In another one, we found a most astonishing thing. There was a doctor in Oakland who had a hundred home visits per hundred visits. And we thought, there is something wrong there. I mean that is really gross. So we looked into it. And here is what we found: the physician was a highly reputed internist in Oakland who practiced in one of the best hospitals in Oakland. He'd had a heart attack, recovered and didn't want to restart practice. But he used to go back to the hospital and have coffee and go rounds and, you know, kind of hang around.

He was getting restless and wanted to do something, but didn't feel that he could stand the strain of opening an office. Talking with one of his friends one day there in the hospital he said, "Gee, is there anything I can do. I just can't think of anything that would be feasible for me to do."

And the other doctor said, "I've got something for you to do. I know you're a good doctor and I would trust you and I know you're not going to take my patients or anything else," he said, "When I'm in the office, occasionally I get a legitimate house call, and I should make it, but if I do, what about my other patients that I've got scheduled for that afternoon? So would you agree, if I put you on call, called you in those circumstances and you would visit Mrs. So-and-So at home who has got this-and-this condition and this is the phone call that we got?"

And the guy said, "That sounds interesting." And he developed a practice of that sort. Now there's a very useful, socially desirable, excellent medical service.

Morris: And he backs up half a dozen physicians.

Breslow: But, statistically, it looks like a nightmare. So that's why we insisted to Paul, "When we identify these physicians, all we say is that it <u>looks</u> odd--let's look into it. And if we find that they really are just running patients through and giving everybody a shot, you know, we've got to stop it somehow."

Morris: So you were doing this--?

Breslow: Paul wouldn't let us do it.

Morris: He wouldn't let you--

Breslow: We did the study, we showed him the data, but he wouldn't let us use the results to try to bear down on what was obviously, for the most part, very bad medical practice.

Morris: Why not?

Breslow: Well--

Morris: You know, there was a deficit already estimated in that first year, I believe.

Breslow: Yes, there was obviously going to be so-called "abuse" in the program, but we might have found some very legitimate situations that you just can't conceive of until you look into them. So, in this case, you have to be very careful not simply to take statistics and declare somebody guilty, as I illustrate by this man in Oakland.

Thus we were not prepared to say, "Just cut everybody off that's giving more than fifty injections per hundred patients" or anything of that sort--we were not that foolish. But we said, "At least let's go the next step and look into it. Even looking into it might have considerable impact."

Morris: And why wasn't Mr. Ward willing to do that?

Breslow: Well, there were several reasons.

Morris: Other than it was election year--

Breslow: One was that the CMA, particularly Ralph Teal, with whom we had to deal in these matters, was against it and for reasons that were consistent with the CMA philosophy: the government shall not interfere with medical practice--whatever doctors do is sacrosanct and nothing can be done to stop them. Now, you know, twenty years later, attitudes have changed somewhat. There's so much money around in these situations that the lawyers have to use part of the money--quite a bit of it, in fact. And one of the issues they're getting into is this very one we're talking about--medical abuse or malpractice. But in those days, the medical association absolutely would not hear of public health getting into it. They're still against it.

Secondly, there was a particular physician who was a pretty powerful force in California medicine who was quite an entrepreneur in many ways--(he subsequently left the country, apparently for his Swiss bank account)--who was involved in this kind of an operation. He had really great political clout.

Breslow: And then a third factor, I guess, was that some of these practices were underway in neighborhoods with a lot of poor people, where there was a different class of doctors identified with these people. It would have been politically difficult (especially for the Brown administration) to be very aggressive with them.

So for essentially medical and other, political reasons, this very obvious thing was not installed.

Morris: Were there similar strong people in the hospital organization and in individual hospitals?

Breslow: They became stronger over the years, but in those days, they were more benign.

Morris: Were doctors involved in contractual relations with hospitals, too?

Breslow: We could have used our data systems to identify hospitals where the data would indicate or suggest at least that things were going on that ought to be investigated.

III GOVERNOR RONALD REAGAN AND STATE HEALTH SERVICES

Transition Discussions, 1966-67

Morris: Was the Medi-Cal program a political issue at all as the gubernatorial campaign proceeded through 1966? Between Pat Brown and Ronald Reagan?

Brewlow: My recollection is that some things were said about this medical program, as things were said about the welfare program in general in the campaign, and that Reagan's attitude was that we were wasting money and throwing money away on people and services where nothing worthwhile was going to be accomplished. While he did not call for repeal or anything of that sort, he indicated in the campaign, I think quite clearly, what his attitudes would be; and which, of course, became expressed. And I can tell you some things about that.

Morris: Then he did get elected--

Breslow: Yes. In November of '66.

Morris: November of '66. And there's a transition period in there when Pat Brown is still in office and Reagan has not yet been sworn in. In the transition period, did any of the Reagan people get in contact at all with your department?

Breslow: Oh, yes. Not about Medi-Cal that I recall. I presume that on Medi-Cal they would have dealt with the Office of Health Care Services--Carel Mulder; later that office became the Department of Health Care Services. But they came to the health department to talk to me. And to me they said that, "We know about this law establishing a term of office for the health director, but we really want you to leave the post so that we can appoint somebody who is on our own team."

Morris: Would this have been the appointments office or Mr. Williams?

Breslow: I forget. I recall Spencer Williams very well; I'm not sure whether I got the message from him first or from somebody else. I don't recall that, but at some point I got it from Spence. So my response--by the way, I did some other things when I was the director of health and I don't know whether you want to cover those or--

Morris: Why don't we deal with the transition and the carry-over years and then if you're strong enough, maybe we can do a quick--

Breslow: Okay, fine. They came to see me. One of the people, not the first, was Spencer Williams, who said that the administration would like to have me leave. To which my response was that I would really like to leave, too. "I have no desire to continue in this administration, but I must tell you about my observation of the law, and the tradition that has been established by the law, which I think is a very good one for California. It has served our state very well, it seems to me. I have no greater love for you than you do for me, but I'd like to consult with some folks about this." He said okay.

And I consulted people, not necessarily the official leaders but people of prominence and in the leadership.

Morris: In state government?

Breslow: Whom I respected in the Cali ornia Medical Association and the California Hospital Association. To both I said, "Look, this is what's happening. I've made a temporary response but I would like to hear what you would suggest, and then I'll have to decide."

Every person to whom I went--I could have gone to some who'd say, "Better step aside," but I didn't go just to my friends. I went to people with whom I'd really argued and fought, and unanimously they said, "You cannot leave. We didn't and we don't care for a lot of things that you stand for, but this is more important. We think it's highly important for you to stay through the term."

With that and with my feeling for the department--by that time, it also had become My Department! I'd been in it for twenty years; and also with a feeling for the people in the department (because I thought that for at least a year I could do something about the people who were there and help with some transition, if that became necessary), I said, "No, I'm going to stay."

Breslow: Well, that didn't please the administration very well. Spence went away and came back, I remember, sometime in January, and said--this started before the first of the year--

Morris: That's the transition period I was thinking about. There was a man named Tom Reed and a man named Paul Haerle who were doing a lot of the organizing and talking to recruits for the governor.

Breslow: I remember their names, especially Tom Reed's. I might have dealt with them, but I don't recall. I do remember that Spencer Williams was involved. He was the one who came back to me, having participated in this communication. "Nothing against you personally," and so on and so on. "We just have a different point of view."

So Spence came in January and said, "Well, okay, we accept that you stay on for a year."

Morris: We put up with you! [laughter]

Breslow: I said, "Fine, and I'll be very glad to work with you under these difficult but possible circumstances."

Then, of course, I became involved with Spencer Williams to a limited extent. Never to the same extent that I was with Paul Ward because we were, by that time, good personal friends.

Morris: You'd been through this Medi-Cal thing together from the beginning.

Breslow: Together, right. So Spence came in and I dealt with him in a very amicable, technical, professional way.

Late in the summer, Spence was quoted in the newspapers here and there as having made speeches--by this time, health was getting to be some matter of public interest--remarking on what a good health director they had: a good department and outrightly recommending me for reappointment.

Morris: Really? Well, that shows great--

Breslow: Well, I went to him and said, "Look, I'm really very touched by this and really honored because I respect you as a person, but it's not going to do any good. It's perfectly obvious that no matter what you say, they're not going to reappoint me. And furthermore, I can't see what good it's going to do you, so why do it?"

He didn't make a big campaign of it, but he quite seriously made the suggestion. Toward the end of the year, he began to quiet down, and I began to hear from people around the country that they were being approached about being appointed.

Morris: They were out doing a search, in other words.

Breslow: Yes, at least they were getting around. You always talk to a lot of people and somebody you talk to isn't necessarily the person you have seriously in mind. Some of them may have been serious possibilities, I don't know about that. In any event, I began to get these calls, and I would lay out the matter as best I could. It was a great department, had a great history, and I hoped it would go forward. It was just clear that it wasn't going to be with my leadership. And as far as the administration was concerned, that, yes, I had profund differences with them. But those who called obviously had to make up their own minds, and if I could help them in any way, or introduce them, or give them history, I'd be glad to help them.

So it got down to the wire, and--

Morris: You mean to the end of 1967.

Breslow: Right. Christmas time, 1967. Meantime, I'd had a very attractive offer in the East, and an offer here at UCLA which I was very much attracted to in the School of Public Health. And so I was beginning to enjoy it, because I was all set to go.

Then a couple of things happened that were kind of funny. One was that the newspapers became interested in the matter. They had always been sympathetic--they generally are to a health department. We are doing public good and don't get paid a lot, and we're a good public service. They were very sympathetic to the department--they had been for years, and to me personally. They heard about this non-reappointment. I don't know how they hear, but they always hear about these things. So they went to the governor and said, "How about this? Here's this great Department of Public Health, and long tradition, great health director, president-elect of the American Public Health Association now," and so on and so on.

The governor responded, "Well, technically, Dr. Breslow is a very competent person, no doubt about that and in the tradition of the health department. It's just that philosophically, we differ."

The papers, of course, have to get the other side of the story. So they came around, and my response was that, "Well, I've had some differences with the governor and his administration, but on that point, we are thoroughly agreed. We do have a difference of philosphy."

The second thing that happened was in the very last few days of the year, between Christmas and New Year's, I believe. I hadn't announced my plans, but had them all made. The administration came

Breslow: around and asked that I stay on, on a month-to-month, day-to-day basis. Of course, that was completely unacceptable and would have been foolish for them, it seemed to me, as well as for me. So I said no, there was no way to do that. At that point, I came here to UCLA on the first of January [1968] and Lou Saylor, then, was appointed from within the department to take over on a temporary basis.

Morris: Did he know it was a temporary appointment?

Breslow: I don't know, but he must have had knowledge that it was temporary. I can't imagine how he would think that he was going to be the director for four years. Maybe he did. Maybe you talked to him.

Morris: No, I haven't talked to him, because I'm not sure where he is.

Breslow: Well, he was a military physician before he came into the department and he retired to live in the Monterey/Carmel area. It's conceivable that he's still around there.

Morris: I'll have to try the phonebook.

Breslow: He'd not been in the department a very long time.

Morris: And then he was director until 1971 or 1972.

Cost Effectiveness, Career Staff Morale##

Morris: Did Governor Reagan's office have any interest in these accounting systems that you had developed, and the information they were providing on possible abuse of Medi-Cal?

Breslow: No, not the slightest. They had even less affinity for that than Paul Ward had.

Morris: Really? If you were concerned with making sure that people were getting quality care and that the money was well spent?

Breslow: They didn't care about money being spent well. From a philosophic standpoint; I'm sure you'll understand this, but many people would not: from a philosophic standpoint, Reagan is an anarchist in the real sense of that word. He does not believe in government except for national defense, and maybe to enforce certain moral codes. As far

Breslow: as government being a service to people, he really does not believe in it. And to me, that's the fundamental guiding principle of the man.

I wouldn't go around making public speeches about it, but that is why I say that they are not interested one bit in who gets the service or what the quality is. They're interested only in preserving [themselves in] office so as to prevent the development of government services for people and to turn everything over to the private sector--everything, as far as I can tell.

Morris: In 1967, you got no sense of concern or interest from the Reagan people in your experience in putting the program, the budget together, and ideas you may have had for making it more cost-effective?

Breslow: Not the slightest. I did make one or two attempts to acquaint Spencer Williams with some of these opportunities. It seemed to me, like it does to you, that at least you could prevent some of the abuse and even loss of money in a way which, was to me, defensible from the public health standpoint because it was preventing bad medicine. And to them, it would be possibly saving money. But they were not interested in that, I presume because it violated the notion that nothing should be done to interfere with the private sector. If they can milk the government, well, what's the government for? As long as the people for whom the services are intended don't milk it, and in this instance they're not--it's the doctors and hospitals who are milking it.

Morris: Interesting. In some of the--

Breslow: You may begin to sense my political orientation.

Morris: It's interesting, you know, that your predecessors made a point of being non-political and yet they obviously thought you did good work and kept you on. So that doesn't seem to necessarily be a problem.

Charles Stewart has been referred to in a couple of articles I've come across about Medi-Cal. Was he part of the group of people that you were working with on putting a budget together?

Breslow: Yes. Chuck Stewart, I think, in those days was in the Department of Finance. I'm not sure whether he was there or in the Office of Health Care Services, perhaps he was in between the two of them. I think he came from the Department of Finance, and you'd have to talk with him to find out precisely what the arrangement was; but he was heavily involved in the Medi-Cal development of which I spoke. When you asked me what did the Department of Finance have to do with it, from a personal standpoint, he was the one and some others, that--

Morris: --testified in Washington?

Breslow: No, I mean within California. He might have testified in Washington, I don't know about that, but he was, within California, involved in the budgeting for the Medi-Cal program.

Morris: Did your ideas and his agree on how you costed things out and set up your estimates, projected your staff, that sort of thing?

Breslow: I don't recall that we had any great differences. We had a difference in point of view, namely, that I thought medical care was intended to improve the health of the people and that was the way we should monitor it and plan for it. His view, I think it is fair to say, was the typical finance guy's point of view that, "I hope it does that, but the main thing is what is it going to cost and what is it going to do to the overall budget and what are the tax implications and what are the implications for other state programs and so on and so forth." In other words, that's the job--what are the finance implications.

Morris: Setting it up in '65 and '66, did Chuck Stewart already suggest that there were going to be costs that would make the Medi-Cal program have an impact on the rest of the state budget?

Breslow: I don't recall that he said that or did that. It's possible, but I don't recall that.

Morris: Okay. How about a guy named Paul Zimmer who was in the Office of Health Care Services in '67? Was he a Reagan person or career civil servant?

Breslow: I don't remember him. I remember Chuck Stewart very well, and the more I think about this, I think he had been in the Department of Finance and he moved into the Medi-Cal field.

Morris: So he was kind of a devil's advocate?

Breslow: Well, I wouldn't--yes, I guess if you want to regard Finance as the devil, yes.

Morris: Oh, I was thinking about it in the sense of somebody whose job it is to keep the budget--

Breslow: Down! To watch what these wild people over in Public Health and those crazy guys like Breslow are thinking about and talking about.

Breslow: But, you see, the reason the Medi-Cal program was so "expensive" to begin with, even compared to other states, was the fact that we provided comprehensive services--not everything, but similar to what New York State was providing. If you look around the whole country at the Medicaid program, it was the wealthiest states, like New York and California, that had the richest programs. They got the most out of the federal dollar. You might think that if you were going to have a Medicaid program funded by Washington, places like Georgia or Alabama--such places, would get a lot of money. But relatively--

Morris: Not if it's a matching basis?

Breslow: That's the point. If it's a matching basis, then we came out ahead. And since we were ahead, my attitude was, let's go for it. It's our people, you know, that we're defending here.

Now, Stewart would have been the one to worry, argue--I can't recall precisely how much--but my recollection is that he was really a very humane man. He was no expert in medical care and he had to regard me, at least, as something of an expert on the medical side. On the other hand, I respected him for his competence, and it was very great, in finance. So, the two of us were involved--

Morris: But coming from different viewpoints.

Breslow: Yes, coming from different viewpoints.

Morris: Aside from Medi-Cal, how did you feel that the things that you wanted to get done with the Department of Public Health: how did those fare with the shift from Pat Brown to Ronald Reagan?

Breslow: Well, the whole notion of preserving quality in state government, in recruiting and keeping good people--professionals--and building programs that are needed as a state public service--that all took a nose-dive. Everything that Earl Warren and the intervening governors, Goodie Knight included, Pat Brown, had developed, just very rapidly deteriorated. We saw that in Public Health. The people were demoralized and everything that was constructive and good began to be challenged, and people began to leave.

Morris: And you could see that in the space of a year?

Breslow: Oh, yes. I didn't think it was possible when I kept on with the job and talked to colleagues and said, "Look, they're jostling me around here, but I've decided to stay on. This is a good department. I encourage you to stay here and keep it going. My term is one year

Breslow: from now, but you people are career people. I urge you to keep building because this is too good. No matter what their philosophy or who they appoint as intermediaries. They can't tear down this department."

I was wrong.

Morris: And it had an impact on things like the crippled children's program and nursing home licensing?

Breslow: Sure. All of the things that had been carefully built up such as quality standards in the Crippled Children's Services steadily deteriorated.

1967 and 1970 Emergency Cutbacks; 1971 Reforms

Morris: What about the reorganizations under Governor Reagan? It looks like several reorganizations, putting pieces of the health department and the welfare department and Mental Hygiene together into Health Care Services.

Breslow: Oh, that kind of stuff was going on before. I suppose I would take a parochial attitude about that, defending the turf, but that's not important, really; I don't think it's very important in retrospect.

Morris: What about winding up, then, with a few of the other things that you did get accomplished in Public Health.

Breslow: Could I, before I do that, could I project just a little bit further into the Reagan administration?

Morris: Sure.

Breslow: Beyond my term of office--is that fair?

Morris: Sure, you were here in Los Angeles participating in some of the state's medical programs.

Breslow: Well, I left state service December 31, 1967, and entered university service January 1, 1968, so I have continuous employment.

Morris: Do you still have a relationship with the state government as a member of the--?

Breslow: Retirement system. But also indirectly as a member of the university. I've retired, actually, officially from both the state and university--it's one retirement system when you've done what I did and link the two with no break in service. So I had thirty-four years of continuous service. I'm continuing to work, really full time, but paid only, because of the system, on a part-time basis. I can only earn a certain amount.

Well, to continue with the Medi-Cal program just a bit. I'll describe what I can recall about it. I'm sorry I don't have as many documents and all as I should have had, but--

The first cutbacks in the Medi-Cal program--substantial cutbacks--occurred in August, they were enunciated at least in August of 1967 and they were labeled "Emergency Program Cutbacks" and began with limitation of services, curtailment of services, dental care reduced to emergency services only, prescription drugs reduced to life-maintaining drugs only. That was never implemented, but it was announced. Physician services restricted the level of charges to the level prevailing in the first quarter of 1967. Physician fees were escalating.

Morris: Oh, you had a raise built into the design?

Breslow: No, fees were whatever the doctors charge: their customary fees. And they were already into Medi-Cal and Medicare--the administration saw what it meant: a bonanza for the doctors, and so they cut allowable fees back to what they had been six months before. Non-county hospital services were limited to a period of eight days of hospitalization without prior authorization, and so on. Thus, the services were first drastically curtailed. That introduced, of course, a lot of confusion and difficulty and remonstrance into the program.

Then again in 1970--there were a lot of other things that went on, but--there was then a substantial second emergency program cutback, I believe, called Cost Trim Regulation adopted in December of 1970. In that emergency program, the amount providers received for services was reduced 10 percent. Physician office services and home visits were limited to two per month without prior authorization. That is, if you had arthritis or something and had to see the doctor more than twice in the month, unless you got someone to give you proper authority, the doctor couldn't be paid for more than two visits no matter how many times you might go to him.

Breslow: Several specific medical procedures were defined as "elective" and placed on prior authorization. For example, you might not be able to have a hernia operation without it.

Morris: You'd have to call the Medi-Cal office and get an okay, is that what that means?

Breslow: Right, and get a prior authorization. This began to break down the so-called mainstream notion and to force people back into the county hospitals. Instead of people being able to find care out in the community, they were pushed back into the county hospitals. County hospitals were also, of course, being paid by Medi-Cal but the people had begun to move away to some extent from those institutions.

Then in October of '71, the so-called Medi-Cal reform program was passed. There were several features to that; I won't try to list all of them, but one was that medically indigent persons were extended Medi-Cal program coverage. Medically indigent person were those who did not qualify for virtue of their welfare category--that is old age, blind, disabled, or in families with needy children. They were other people, for the most part adults, who were extremely poor and needed medical care. They were called "medically indigent persons." Originally, they had not been taken onto the Medi-Cal program; they were left as a county responsibility. But the state now found it advantageous to take them into the Medi-Cal program, in return for certain financial arrangements with the counties, which the counties at the time also found advantageous. So that politically it made possible--

Morris: There were shifts between the county and the--?

Breslow: Shifts, yes. So that some federal funds could be picked up as well as state funds to help pay for the care of these persons. The number of those at one point reached as high as 800,000 persons, so it was not an inconsiderable program.

Another feature, and the one I'd like to speak to you about just a little bit, was the so-called Pre-paid Health Plan [PHP]. Originally, the Medi-Cal legislation had envisioned the development of a Kaiser-type service: namely, a pre-paid, group-practice plan, which is regarded as more economical than the other kinds of plans, giving an equivalent service. The people would have the opportunity to choose that kind of a service, just like state employees and federal employees and many, many other people could choose. It was part of the mainstream idea. It was never really implemented during this first year or so of the program, but by 1971 they began to implement it.

Breslow: What they did was to create a kind of a service that became a state and, in fact, a national scandal. Namely, they set up a system of awarding contracts which selectively would pick the cheapest, poorest group of doctors. They were out simply to milk the program and were not interested, seriously, in providing care that would do good for health. So they assembled into these pre-paid health plans. Some of them were honest, sincere, good doctors; but for the most part what the new, Reagan administration-sponsored so-called prepaid health plan did was promote the worst kind of health care. They got the cheapest doctors and the poorest hospitals that would set up some kind of combination service and offer a contract to the state to provide care at a low cost. And that was the only interest. That was the Reagan administration aim in pre-paid health plans, namely, to reduce the cost.

Morris: The people in the medical association had no concern about poor, inadequate doctors?

Breslow: Not really.

Morris: That's curious, given the high standards that the medical profession is generally accepted to hold. There must be some fascinating discussions at medical meetings between the public health part of the profession and the direct-care part of the profession.

Breslow: There aren't so many discussions. We each know what the other stands for. There is some crossover. I'm called on occasionally to visit medical associations. I remember one time, Senator [Edward] Kennedy and the AMA, a few years ago, got together because they were going to have some dialogue. They sponsored jointly--Senator Kennedy and the AMA--sponsored a one-day, big health conference in Washington, D.C. Can you imagine that?

Morris: It must have been something.

Breslow: Very interesting. They selected me to give the keynote speech. But what I'm going to tell you isn't in that speech. I won't keep you much more.

Morris: Did UCLA hospital become involved at all in--?

Breslow: Only in that they would see they would be providing patients with care. Not a great amount, but to a small extent. There have been a lot of changes, but that's a whole other story. You want just what happened the first year or two [in the Medi-Cal program].

Earl Brian as Administrator; Prepaid Plans Begun

Breslow: The person that the Reagan administration brought in as the director of health and then as the head of Health and Welfare, to which he gra ated, perhaps you know, I think you interviewed, Earl Brian.* And perhaps you know that his history was that of being a resident, I think in surgery, at Stanford.

Morris: Didn't he serve as secretary to the State Board of Social Welfare or something? For a brief period in '66. That's probably not something you would have had any reason to--

Breslow: No, all I know was that he was a Vietnam veteran, and that he did not complete his graduate medical training, but was very interested in politics and participated in the Reagan campaign and was brought in to head the state health agency [Department of Health Care Services] and then the Health and Welfare Agency. He was very much involved in this so-called reform act, Medi-Cal reform act in 1970--

Morris: 1970 and '71.

Breslow: Right, and in the prepaid health plans and the implementation of them, And I think it's only fair for history to note that he was appointed and accepted the position in state public health (which, as I've described it to you, goes back for some decades) he accepted that position without the training or fundamental interest in the field. He never had expressed any interest in the field prior to accepting the appointment. His principal role was in the development and implementation of the 1971 Medi-Cal Reform Act; and then in the curtailment of services and of the implementation of the PHP--a portion of that program. The first contracts were signed in May of 1972.

Related Concerns: State Board of Health, Health Care in Minority Communities, Hospital Planning

Breslow: I know you wanted to go back, and so do I--it's getting a little late in the day--to other things that might be pertinent to my serving as the director of the State Department of Public Health.

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*See interviews with Dr. Brian and Dr. Roberta Fenlon in this series for further discussion of the Department of Health Care Services and the California Medical Association, respectively, in relation to the Medi-Cal program.

Breslow: I should mention that I helped to bring in to the state health service one man who has been very important and is quite well known in the state and in the country. That's Roger Egeberg. Pat Brown appointed a commission early in his term of office. He called it the Governor's Commission on Medical Aid and Health. In those days, I was the chief of the Division of Preventive Medical Services--Gordon Cumming was the chief of the Bureau of Hospitals. The two of us were assigned as staff to work with the commission and I helped to recruit Roger Egeberg who was then the medical director of the Los Angeles County Hospital Service.

They put him in as the chairman of that commission in 1960 or thereabouts. After that experience, we recruited, and I think it was still during Merrill's term, Roger Egeberg to serve as the chairman of the State Board of Health. He continued on for some time as the chairman of the State Board of Health, I think through most of the sixties, essentially through the Brown administration. I was very comfortable to be the director of Public Health with Pat Brown, Paul Ward on that side; and Roger Egeberg and other very good people as members of the State Board of Health to whom we would come every month or two with agenda items for which the board would have the responsibility of making some important decisions--adopting regulations that would have effect on hospitals and health generally.

In that situation as director of health, I'd just like to mention quickly the things that I tried to do, that I thought were most important.

First, to maintain and develop a science base for Public Health upon which the department had long prided itself and still had a good base. This was in '65 when I become the director.

A second major interest of mine was to develop data for public health that reflected my long interest--

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Breslow: --in continuing the high standards and leadership of the department. I'm not thinking of myself in that connection, obviously, but of the people who were serving as division heads and bureau chiefs during that period. There were some really splendid people who had positions of national leadership in the whole public health movement. In that connection, I was interested in recruiting people like Bob Day and other people I have mentioned.

Breslow: And finally, I had great interest in the quality and equity of medical care. I've indicated to you already my interest in preserving the quality of care. With respect to equity, I would like to tell you about one incident and maybe this should be the end. In 1965, you may recall, there was a terrible episode in Los Angeles, sometimes called the Watts Riot. It was just shortly thereafter, that same summer, that I became the director of Public Health. And when those things occurred, the McCone Commission was established to study what could be done. Milt Roemer, a member of the faculty of the [UCLA] School of Public Health, was drawn into the work of the McCone Commission to make a study specifically of the health and health care implications--what should be done about them.* I took an interest in the situation from the standpoint of the state health department. And what I discovered was that our department--I knew about this situation as chief of the Division of Preventive Medical Service, because the work was done in that division by the hospital people, but I had authority only on becoming director of the department, a newly acquired authority, to do anything about these matters--that we had responsibility for dividing the state into regions for hospital planning purposes.

Morris: What is referred to by that dreadful term, "the hospital catchment area"?

Breslow: Well, that was the mental health term; I don't think people in other parts of health used it so much as the people in mental health. But in any event, it's the same idea: regionalization of services. These lines had been drawn some years before, and it looked on the map as though everybody had hospital services, that some new hospitals were needed (they were still being given some federal and state assistance under a program that had been established in the late 1940s--the Hill-Burton program).

So we had a map of the state, all divided up, and each one was a hospital region.

I said, "I'd like to take a look at the hospital region of Watts because I hear terrible things about that." So the map is brought in and we look at it and here is an oblong area in the middle of Los Angeles, a rectangular area several miles long and, I guess, a couple of miles wide, right in the middle of the city, that had no hospitals.

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*See "Health Resources and Services in the Watts Area of Los Angeles," Milton I. Roemer, California's Health, February-March, 1966, pp. 123-143.

Morris: That's incredible.

Breslow: There were some hospitals on the periphery, on the very edges. Very small, very poor hospitals. So small that they could be nothing other than poor. Mostly small, proprietary hospitals. Most people who got sick in Watts had to be what they called $10 sick (That meant they would have to take a taxi cab for $10 to get to the big county hospital, because to go on the bus would require three transfers. That was completely unfeasible for anybody who was seriously sick) so they had to be $10 sick to get to the county hospital.

I said, "My goodness, how can that be?" Well, it was very simple. The area was all regionalized. The only trouble was that the right upper quarter of Watts was drawn into an adjacent hospital area where there were better living conditions over there, and the left upper quarter was drawn off similarly.* The whole of Watts was just quartered into other areas where there were hospitals, but not to serve the people in Watts.

Morris: When those areas had originally been drawn, the population in Watts was different?

Breslow: It might have been. All I can say is, I hope so. But in any event, that was our situation in 1965. So one of the very first moves that I made as director of Public Health was to re-draw those lines, and

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*"A principal hospital resource for the 251,000 persons in the South-Southwest Districts is the Los Angeles County General Hospital--both for bed-care and organized outpatient services ... an 8 or 10-mile automobile or ambulance trip ... Other patients from Watts and the remainder of the South-Southeast Districts seek hospitalization at Harbor General Hospital, John Wesley, St. Francis and California Hospitals (also fairly near these districts), the local proprietary hospitals and, to a limited extent, at many other hospitals in the Los Angeles region. It must be pointed out, however, that the hospital resources for physicians practicing within the South-Southeast Districts are not these peripheral institutions of good quality but, in the main, small proprietary hospitals within the districts reviewed earlier. The institutional influences on their mode of practice would be correspondingly limited." Roemer, ibid, p. 127.

Breslow: the State Board of Health approved. Suddenly, from being at the end of the list to qualify for a new hospital, the Watts area became number one to qualify. Because they had nothing.

Morris: So the riots became something to pay attention to in health services.

Breslow: So Watts got federal and state money. Then we got a lot of jockeying as to who would get the money to help build a hospital. I remember that there were some private interests in the Watts area that wanted to build a so-called voluntary hospital. These government--federal and state--funds could not be allocated for private hospitals in the profit-making sense, but they could go to a non-profit hospital or a government hospital. Kenneth Hahn, the county supervisor then and now, took the lead down here in developing a county plan to build a hospital using county funds as the local matching funds. That's how the King Hospital came into being.

Morris: Martin Luther?

Breslow: Martin Luther King [Jr.] Hospital, right. That was the upshot of it.

Morris: Would the public health department have been involved in the multi-service center ideas which, I gather, were set up in Watts and then tried in other areas where there were concentrations of low-income and minority people?

Breslow: I don't recall that the federal or state funds for those came through the state health department. The tendency developed in those days, you may remember, for the government to deal more and more directly with local groups and agencies. And I'm not quite sure how that Watts community health center did develop. You may know that it's become quite a notable enterprise.

Morris: It's still continuing?

Breslow: Oh, yes.

Morris: And it grew out of this--

Breslow: Out of this and the OEO days, right.

Morris: Now, why don't we stop here.

Breslow: Yes, I think that's about enough.

San Francisco Chronicle, March 27, 1968

Angry Revolt By State Health Board

By Carolyn Anspacher

The State Board of Health revolted in fury yesterday against an "efficiency report" compiled by the Reagan administration's task force, and the board president charged the intent is to "scuttle" the State Department of Public Health.

Dr. Roger O. Egeberg, board president and dean of the University of Southern California Medical School, shouted: "I am goddamned mad and I do not propose to be quoted as saying I am very angry."

What roused his rage was the fact that the three-month-old task force report, still marked "top secret" and "confidential," has never reached the board. It is known, however, that among the 120 recommendations is one that would cut the ten-member board back to five—to one "consumer," one dentist and three practicing physicians.

SUMMARY

Some of the task force's recommendations have been synthesized in the press and a few others have been summarized in the $25-a-copy book covering every facet of State government.

Traditionally, and under both Republican and Democratic governors, the board has been made up of a medcal school dean, the dean of a university school of public health, the director of the State Department of Public Health, a pathologist, an orthopedist, a county sanitarian experienced in environmental problems, a general practitioner, a dentist with public health experience, the medical director of a county hospital and a public representative in public health problems. They serve four-year terms.

So far, Governor Ronald Reagan has made three appointments to the board: Dr. William McColl, West Covina orthopedist; Dr. William C. Herrick, La Mesa pathologist, and Albert A. Marino, Placer county sanitarian. The other board members were appointed by former Governor Edmund Brown.

Both at the board's open meeting at the Fairmont Hotel and later at a press conference, Doctor Egeberg ripped into the report and, obliquely, at the task force that compiled it.

He described the recommendations as "sadistic

See Back Page

Health Board --Revolt on State Report

From Page I

prestidigitation" and "an insult to the board."

"To create a board of five, composed of one consumer, one dentist and three practicing physicians who know

(continued from previous page)

nothing of environmental problems, is a punitive effort to kill the Department of Public Health," he said.

Dr. Hamlet Pulley, acting director of public health, acknowledged that two copies of the voluminous task force report had reached his office but both had been marked "restricted" and "for administrative purposes only." I was told only department heads could see it."

"Well, I want to know why in hell we haven't seen that report in the last three months," Doctor Egeberg roared. "This board was created to be advisory, administrative and supportive and we have the right to see what destruction is planned for the bureaus we're supposed to be supporting."

DEMAND

The board took the unusual stand of unanimously—including the Reagan appointees—"demanding" copies of the report. Then—and again unanimously—decided to hold a special closed meeting to consider the recommendations when they get copies of the report.

"If necessary, to avoid violating the Brown Secrecy in Government Act, I shall appoint this entire board a special subcommittee to consider urgent problems of personnel," Doctor Egeberg snorted.

Detonator of yesterday's unexpected explosion was San Francisco's doughty Lawrence Arnstein, known for generations as "Mr. Public Health."

The 87-year-old Arnstein appeared before the board to comment that if the task force recommendations were implemented, the Department of Public Health would be "reduced from the rank of one of the best—if not the best in the United States—to a second rate department unworthy to serve the people of this State."

'DISASTROUS'

He, too, termed "disastrous" the proposal to cut the State Board of Health in half, plans to weaken every facet of the department, and recommendations that internal committees of the department recommend abolition of jobs and whole bureaus.

Arnstein urged the creation of a committee of three leading experts in the field of public health to evaluate the task force recommendations "for the benefit of the Administration."

Also read into the record was a letter expressing the "great concern" of the California Congress of Parents and Teachers over the three task force recommendations that have been made public.

Mrs. Laurence B. Martin, president of the organization, also urged further study and evaluation by leaders in the area of public health.

CONCERN

Of particular concern to the congress, Mrs. Martin wrote to Governor Reagan, are proposals to transfer many responsibilities of the State department to local health offices, and the great reduction or even total elimination of research projects.

"The first one could well mean the complete elimination of many necessary health services and facilities since most counties cannot or will not assume additional responsibilities without additional State financial assistance," the letter said.

"The proposed curtailment of the department's research functions would pose a serious threat to the meaningful health programs for which this State has earned an enviable reputation.

"The health needs and problems of Californians must be identified before methods can be devised to meet these needs and solve these problems, and the constantly changing health picture requires continuous research."

Before enacting its regular business, the board unanimously adopted a resolution reaffirming its insistence that the qualifications and the term of office for the director of public health, as set forth in the State Health and Safety Code, remain unchanged.

Last December, when Reagan did not re-appoint Doctor Lester Breslow as public health director, it was widely reported that the job qualifications were to be so downgraded that anyone with a medical degree and a license to practice in the State could head the department.

At the present time, applicants are required additionally to have a year's postgraduate training in a school of public health and five years' practical experience in administration of a well-organized health department.

No replacement has yet been found for Doctor Breslow, one of the Nation's leading public health authorities. He is now professor of health services administration at UCLA.

DR. ROGER EGEBERG
'Goddamned mad'

LAWRENCE ANRSTEIN
He touched off the blast

Dr. Breslow was sent the preceding March 1968 newspaper article with his oral history transcript and the following queries:

I just came across this clipping about the survey Governor Reagan's people did on Public Health and the rest of state government shortly after he took office: do you recall any meetings with task force people assigned to your department? What suggestions did they make? Why was the report marked secret? How did the fuss with the Board of Health work out?

The summary report of the task force says there had been a shift in recent years (1960s) from service to research in the Department of Public Health and questioned whether DPH should do basic research. What was that all about? And did anything happen to change the Department's focus?

In a letter dated 19 November 1984, he replied:

With respect to the questions on the clipping from the 27 March 1968 issue of the San Francisco Chronicle, I would note first that that newspaper story appeared several months after I had left office, and I did not recall then nor do I recall now anything about the report mentioned, beyond what was reported in the newspaper article itself. You asked, "how did the fuss with the Board of Health work out?" It worked out as the Reagan administration intended, namely the total dissolution of the Board of Health. That had the consequences that Mr. Arnstein pointed out at the time it would have, namely, taking the California Department of Public Health out of the first rank of health departments in the country.

You also question the mention of research in the Department. All of the research conducted by the Department was either laboratory or epidemiologic investigations closely geared to the Department's mission. For example, laboratory studies involved identification of viruses that were causing disease among the people in the State. Epidemiological studies were directed, for instance, to the causation of the chronic diseases as well as causation of infectious diseases that were affecting the people of the State. All of the research was of a nature that could probably best be conducted by a state department of public health. The studies that were conducted contributed considerably to the good reputation of the department in those days throughout the country and beyond.

Transcriber: Lindy Berman
Final Typist: Keiko Sugimoto

TAPE GUIDE -- Lester Breslow

Date of Interview: April 5, 1984

APPENDIX A - From American Journal of Public Health, Vol. 59, No. 2, February 1969

This paper describes certain surveillance techniques used during the first year and a half of the "Medi-Cal" program. The use of computers within new health programs is discussed, and future possibilities for electronic technology are indicated.

STATISTICAL SURVEILLANCE OF A TITLE XIX PROGRAM

Henry Anderson, M.S., M.P.H.

Introduction

FOLLOWING Congressional enactment of Public Law 89-97 in the summer of 1965, California's legislature met in special session to consider legislation which would enable California to participate in the law's Title XIX provisions. Implementing legislation, signed by the governor on November 12, specified that a new California Medical Assistance Program, with an exceptionally broad scope of benefits, would begin operating March 1, 1966. This program is now popularly known, and will hereinafter be referred to as "Medi-Cal."

The "single State agency to administer the plan," required by Section 1902(a)(5) of Title XIX, in California is the Health and Welfare Agency, established some years ago to coordinate the activities of the State Departments of Public Health, Social Welfare, Mental Hygiene, and Rehabilitation. Specifically for the purpose of administering the Medi-Cal program, a new entity, called the Office of Health Care Services (OHCS), was created within the California Health and Welfare Agency. OHCS undertook some program functions itself, such as fiscal auditing. For the performance of other functions, it contracted with outside agencies, some private and some public. Among these was the California Department of Public Health.

This department has long had responsibilities for licensing hospitals and nursing homes in California. It was assigned certification responsibilities under Title XIX, and assigned new responsibilities for consultation with professional groups concerning their participation in Medi-Cal. Finally, within the department a Surveillance Unit was created to (1) "provide accurate and complete statistical review of vendor activities designed to produce effective program management"; (2) provide data necessary "for determination of reasonable rates and charges for services"; (3) "engage in a continuing medical care review . . . in order to carry out the intent of the law that persons receiving care under the (program) shall receive care equal in quality to other portions of the population."

In September, 1967, among other administrative changes, the Health and Welfare Agency removed the surveillance function from the Department of Public Health. This article is limited to describing certain surveillance techniques developed during the first 18 months of the Medi-Cal program, when the Department of Public Health was the responsi-

ble agency. Data on total program expenditures* or numbers of eligible persons,† for example, are outside the scope of this presentation, as is any conjecture on the types of surveillance which the agencies now responsible may carry out in the future.

Data Retrieval Process

From the outset, "fiscal intermediaries" were designated by OHCS to receive, process, and pay claims. California Physicians Service (Blue Shield) handles the claims of physicians, dentists, pharmacists, and a wide variety of auxiliary and ancillary practitioners. The Blue Cross plans of Northern and Southern California are responsible for payment of bills submitted by hospitals, nursing homes, and other types of institutions and agencies.

By the end of the first year of the program, Medi-Cal claims were flowing into CPS at a rate of over 1,500,000 per month, while Blue Cross of Southern California was processing about 60,000 monthly, and Blue Cross of Northern California about 45,000.

Certain items of information, such as type of procedure and primary diagnosis, are coded by fiscal intermediary clerks. These items, along with date of service, units of service, amount of payment, claim and check numbers, and identification of recipient and vendor (both by name and by number) are keypunched and then transferred from punch cards to magnetic tapes. The original claims are retained in microfilm form. Claims which are questionable—usually for fee levels—may be withdrawn from the process before keypunching, and referred to a medical adviser. Others may be withdrawn as a result of edits of the claims tapes, principally for patients' eligibility. Checks are automatically prepared from the claims tapes which pass the edits.

After payments during a given month were completed, the fiscal intermediary retrieved basic information concerning each payment, and sent the resulting transaction tapes to the Data Processing Center of the State Department of Public Health.

The Data Processing Center "cleaned" the tapes for use with the department's computer—an RCA Spectra 70/45 with a core capacity of 65 K and six tape drives—and sorted them by vendor license number. Two characteristics of these tapes should be noted: (1) They were limited to completed payments. The Surveillance Unit did not receive information on claims as originally submitted, with whatever downward adjustments or outright rejections may have been made by the fiscal intermediaries. (2) All transaction tapes received by the Department of Public Health were organized by the month when payment was made rather than by the month when service was rendered.

Month-of-Payment Versus Month-of-Service Data

For such purposes as reporting to the federal government on current program expenditures, month-of-payment data are necessary and sufficient. During the early months of the Medi-Cal program, the Surveillance Unit worked with

* Medi-Cal was budgeted for a little less than $600 million in fiscal 1966-1967 and a little more in 1967-1968. Due to delayed billing by and delayed payment of some major providers of services, actual obligations against the program are a matter of considerable controversy, as is the projection of how much will be expended in the future. Estimates of the program's deficit have ranged from $210 million to practically no deficit at all.

† Nearly 1,500,000 persons are presently eligible for Medi-Cal benefits, of whom about 1,300,000 are "cash grant" recipients of Aid to Families with Dependent Children, Old Age Security, Aid to the Blind, or Aid to the Totally Disabled, and about 160,000 are "medically needy." Among the latter, about 55,000 are eligible for the full scope of Medi-Cal benefits, while about 105,000 are eligible for some particular benefit (usually insititutional care) to meet some particular need.

month-of-payment files in its own activities. But it soon became evident that most surveillance operations were more meaningful when based on data organized by month of service rather than by month of payment. One of the major contributions of the Surveillance Unit was primarily methodological rather than substantive: designing month-of-service files. This was a formidable charge upon the department's Data Processing Center. For example, payments made to physicians in May, 1967, had to be merged into a data bank which by that time had reached approximately ten million records* on nearly 100 reels of computer tapes, classified by 15 possible months of service. Furthermore, it was not considered enough to add new payments randomly to the end of existing month-of-service tapes. All reels were organized by type of vendor, individual vendor within type of vendor, and within individual vendor by county, aid category, and personal identification of recipient.

Prior to this achievement, all utilization review, budget estimates, and the like, were limited to month-of-payment data clouded by an unknown but substantial "X" factor: services for which the program was liable, but which had not yet been paid, either due to delays by vendors in submission of their bills or delays by the fiscal intermediaries in the payment of bills. The vagaries of month-of-payment data are illustrated, for example, by the fact that payments to physicians during February, 1967, were $5,146,798 while in April, 1967, they were $24,637,863. Month-of-service data suggest that, in fact, the level of physicians' participation in the program was relatively stable throughout this period, from about nine to ten million dollars per month.

* The department's total Medi-Cal data bank was at that time about 20,000,000 records, but physicians' records were maintained separately from the two other largest files of claims: pharmacies; hospitals, and other types of institutions.

For all its advantages, however, there is a major problem inherent in month-of-service analysis (in addition to its heavy demands on computer time): it does not begin to yield meaningful results until many months after the fact. Under Medi-Cal regulations, vendors could submit claims up to six months after the performance of a service, but effective January 1, 1968, this was reduced to two months. The fiscal intermediaries are expected to pay approved claims within 30 days of receipt, but this limitation does not apply to the payment of claims which are questionable in any respect.

If the proportion of late cycling were fairly regular, and the claims paid early were representative of those paid late, one might draw conclusions about month-of-service experience by projecting data, for example, after three or four months of payment were accumulated. But these conditions do not obtain. The items paid late are, almost by definition, atypical; moreover, they are not released in a steady stream. The Surveillance Unit found, for example, that within the space of a few days in April, 1967, payments of nearly $1,500,000 were made for physicians' services which had been performed ten months earlier, in June, 1966.

As this is being written, the most recent month-of-service data which seem reasonably complete are from December, 1966, and in some of the discussion it is felt appropriate to refer to even earlier, and therefore more nearly complete, months of service.

Patterns of Practice

Units of Service

One of the basic assignments of the Surveillance Unit was to study "norms" of practice within the Medi-Cal program, and significant "departures from the norms." The first step toward meeting this charge has already been mentioned: the organization of month-of-service files

Table 1—Distribution of services among participating physician groups and individual practitioners. California Medical Assistance Program, November, 1966 (month of service).

Units of service	Total		Individual practitioners		Groups	
	No.	%	No.	%	No.	%
Total	18,008	100.0	17,186	100.0	822	100.0
1– 4	3,256	18.1	3,108	18.1	148	18.0
5– 9	2,342	13.0	2,261	13.2	81	9.9
10– 24	3,795	21.1	3,671	21.4	124	15.1
25– 49	3,100	17.2	3,005	17.5	95	11.6
50– 99	2,586	14.4	2,482	14.4	104	12.7
100–199	1,725	9.6	1,607	9.4	118	14.4
200–299	545	3.0	505	2.9	40	4.9
300–399	256	1.4	225	1.3	31	3.8
400–999	349	1.9	293	1.7	56	6.8
1,000 or more	54	0.3	29	0.2	25	3.0

NOTE: Includes payments made through May, 1967. Percentages may not add to 100.0 due to rounding.

into "profiles" consisting of each participating vendor's claims paid by the program. The second step was to devise ways of classifying these "profiles" into frequency distributions, which would begin yielding insights into what was normative Medi-Cal practice and what was significantly "deviant." After experimenting with many such techniques, and rejecting those which were unfeasible or ambiguous, some 23 ways of classifying practitioners' profiles were retained. For example, each month, every participating vendor was classified according to the number of different Medi-Cal recipients he had served, the total number of services rendered, and the average services per recipient.

Table 1 illustrates this type of frequency distribution: participating physicians grouped according to the number of units of services they rendered in a given month of service. "Unit of service" was defined as a visit, injection, surgical procedure, laboratory test, x-ray, or any other identifiable service billed by the physician himself.

In California, over 23,000 physicians, practicing alone or in groups, are available to the public and therefore theoretically available to Medi-Cal recipients.* Table 1 shows that about 18,000 physicians were paid for one or more services rendered in November, 1966. Thus, during that month, about 5,000 physicians were "available," but did not participate in the Medi-Cal program. (In most other months studied, the proportion of nonparticipating physicians was even higher.) If these nonparticipants are added to "light" participants —defined as those providing fewer than 10 units of Medi-Cal service in the month—it is found that over 10,500, or nearly half, of the eligible physicians in the state are participating minimally or not at all. Taken as a whole, this group provides less than 5 per cent of all physicians' services under the program.

On the other hand, a relatively small

* Over 10,000 other licensed physicians are retired on salary in research or administration, in county, state, or federal hospitals, or for other reasons not in a position to submit bills to the Medi-Cal program. They have been omitted from all calculations of the extent of physician participation in the program.

proportion of the state's eligible physicians are "heavy" participants in the program. As Table 1 reveals, 1,052 individual practitioners and 152 physician "groups" (most of which are two or three member partnerships rather than groups in the full sense), each provided 200 or more units of service to Medi-Cal recipients in November, 1966.* These physicians, representing about 5 per cent of those eligible, rendered about 45 per cent of all units of service in that month. Essentially the same centralization of services among relatively few physicians was observed in all the other months studied by the Surveillance Unit. No noticeable tendency toward greater dispersion of services throughout the medical community was observed during the first 18 months of the program.

Much the same pattern of concentration is found when dollar volume is measured rather than units of service (see Table 2). Physicians receiving payments of $2,500 or more for services performed in November, 1966, comprised fewer than 2 per cent of the eligible physicians in the state, but they received nearly one-fourth of all physician payments under Medi-Cal. Those with payments of $1,000 or more comprised fewer than one-tenth of the physicians eligible to participate, and received more than half of all physician payments.†

Services per Recipient

Another dimension of each participating practitioner's pattern of Medi-Cal practice was obtained by dividing his total units of service by the number of different recipients served, which yielded the average services per recipient in his Medi-Cal patient load taken as a whole. In Table 3, participating physicians are grouped according to this dimension. For purposes of comparison,

* The leader among individuals was a general practitioner who performed 1,996 services during the month. In terms of different recipients seen, the leader was an obstetrician-gynecologist who provided one or more services (1,844 altogether) to 582 Medi-Cal patients in the course of the month.

† In November, 1966, the leader among individual practitioners in this respect was a general practitioner who received payments of $10,228 for the services he rendered to Medi-Cal recipients during the month. In other months, individual practitioners received as much as $15,745 for their Medi-Cal services.

Table 2—Distribution of payments among participating physician groups and individual practitioners. California Medical Assistance Program, November, 1966 (month of service).

Payments	Total		Individual practitioners		Physician groups	
	No.	%	No.	%	No.	%
Total $	18,008	100.0	17,186	100.0	822	100.0
1– 49	3,685	20.5	3,506	20.4	179	21.8
50– 99	2,289	12.7	2,217	12.9	72	8.8
100– 249	4,121	22.9	3,978	23.1	143	17.4
250– 499	3,331	18.5	3,229	18.8	102	12.4
500– 749	1,613	9.0	1,535	8.9	78	9.5
750– 999	974	5.4	924	5.4	50	6.1
1,000–2,499	1,541	8.6	1,437	8.4	104	12.7
2,500–4,999	356	2.0	305	1.8	51	6.2
5,000 or more	98	0.5	55	0.3	43	5.2

NOTE: Includes payments made through May, 1967. Percentages may not add to 100.0 due to rounding.

physicians. California Medical Assistance Program, March and November, 1966 (months of service).

Services per recipient	Physicians			
	March		November	
	No.	%	No.	%
Total	17,315	100.0	18,008	100.0
1.00–1.49	3,531	20.4	3,318	18.4
1.50–1.99	2,257	13.0	2,351	13.1
2.00–2.99	4,683	27.0	4,810	26.7
3.00–3.99	2,858	16.5	2,729	15.2
4.00–4.99	1,446	8.4	1,574	8.7
5.00–5.99	783	4.5	862	4.8
6.00–6.99	478	2.8	554	3.1
7.00–9.99	702	4.1	1,020	5.7
10.00 or more	577	3.3	790	4.4

NOTE: Includes payments made through May, 1967. Includes medical groups and individual practitioners. Percentages may not add to 100.0 due to rounding.

two months of service are included: March (the first month of the program), and November, 1966.

Some of the high averages were based on a relatively small Medi-Cal patient load. Some, however, were based on extensive numbers of Medi-Cal recipients.* As measured by this index, the proportion of "heavy" utilizers appears to be increasing. In March, 1966, 10.2 per cent of the participating physicians rendered an average of six or more services per Medi-Cal patient. In November, the comparable figure was 13.2 per cent.

Injections

The relationship between number of patient visits and number of injections was another of the ways devised by the Surveillance Unit to classify each participating physician's "profile." Injections, as here defined, did not include immunizations, which could be expected to appear frequently in a practice with large numbers of Aid to Families with Dependent Children (AFDC); nor did it include infiltrations of joints, injections preparatory to radiology, and the like.

As Table 4 reveals, the use of injections in a representative month of service (November, 1966) was very unevenly distributed. Most participating physicians used (or, at least, claimed and were paid for) very few injections, if any. Some, however, claimed a ratio between injections and visits of at least 1:1.† Although this minority is still small, it more than doubled in the first ten months of service studied: from 0.7 per cent of participating physicians in March, 1966, to 1.5 per cent in January, 1967. This fact may be significant, both for the quality of care under Medi-Cal and its costs. As will be seen below, the average payment per injec-

* In March, the leader among those with more than 100 recipients was a general practitioner who provided an average of 7.6 services to the 229 Medi-Cal patients he saw during the month. In November, the leader was a pediatrician who provided an average of 9.5 services to his 111 Medi-Cal patients.

† Among individuals, one general practitioner claimed, and was paid for, 340 patient visits and 454 injections; among "groups," a two-man partnership claimed, and was paid for, 1,179 patient visits and 1,122 injections.

than the payments for any other physician procedures studied.

Other Patterns of Practice

In addition to the dimensions mentioned above, the Medi-Cal claims of participating physicians were also examined in terms of initial visits compared to follow-up visits; routine visits compared to extra-charge visits; office visits compared to out-of-office visits; surgical procedures; radiological procedures; and diagnostic services other than radiology.

The foregoing dimensions, while appropriate to analysis of medical practice, were inappropriate to most types of practitioners. The patterns of Medi-Cal practice of the following types of practitioners for the most part were examined only in terms of total units of service, number of different recipients, average services per recipient, and total payments: dentists, pharmacists, optometrists, dispensing opticians, occupational therapists, private duty nurses, clinical laboratories, hearing aid companies, ambulance companies, prosthetists and orthotists, other (medical equipment rental agencies and so on).

The surveillance function did not end with the preparation of these sets of tables each month. The same omnibus computer program, which classified participating vendors by the various indexes mentioned, also listed by license number those falling above "cutting points" which the Surveillance Unit and its professional consultants considered so unusual as to suggest a potentially questionable pattern of practice. For instance, in June, 1966, 400 physicians in individual practice, 26 medical groups, 90 dentists, 73 optometrists, 54 dispensing opticians, 116 chiropractors, 40 podiatrists, and 66 vendors of other types were identified as falling outside the "cutting points" with respect to one or

Table 4—Relationship between patient-visits and injections among participating physicians. California Medical Assistance Program, November, 1966 (month of service).

Office, home, and nursing home visits*	Total	Injections†									
		0	1–4	5–9	10–14	15–19	20–24	25–49	50–99	100–199	200 or more
Total	18,008	11,289	2,938	1,206	591	416	275	636	384	188	85
0	3,416	3,379	29	3	1	3	1	—	—	—	—
1– 4	4,136	3,644	472	18	1	1	—	—	—	—	—
5– 9	2,349	1,654	548	122	13	8	3	1	—	—	—
10– 14	1,464	798	453	139	47	13	10	4	—	—	—
15– 19	990	452	329	133	50	16	1	8	1	—	—
20– 24	814	345	259	109	46	29	14	10	2	—	—
25– 49	2,059	578	532	368	200	152	93	121	13	2	—
50– 99	1,481	280	228	224	156	140	100	231	116	6	—
100–199	802	112	64	68	63	43	47	187	158	58	2
200 or more	497	47	24	22	14	11	6	74	94	122	83

* Procedure codes 9000-9008 and 9010-9018 from California Medical Association, "Relative Value Studies" (4th ed.), 1964.

† Defined by fiscal intermediary as "9900: Necessary injections given by the physician (Medicare-Medi-Cal)." Does not include injection procedures elsewhere defined in the "Relative Value Studies" of the California Medical Association (4th ed.), 1964: 1046 (injection into joint); 1413 (injection into bursa); 2433-2440 (injections for venography, angiography, etc.); 9040 (immunizations).

NOTE: Includes payments made through May, 1967. Includes medical groups and individual practitioners.

more dimensions of their Medi-Cal "profiles." These cutting points were set at such levels that only about one-fourth of 1 per cent of the practitioners were identified in any single dimension of concern.

No practitioner was evaluated through computer operations alone. From the lists of practitioners falling beyond the cutting points each month, the Surveillance Unit selected the most extreme cases,* returned these license numbers to the Data Processing Center, and obtained complete listings of each of these practitioner's total claims for the month. Those scrutinized in this detail were never more than a fraction of those appearing on the initial "deviant" lists.

To return to the example of June, 1966: after examining the computerized lists of possible "deviants," the Surveillance Unit obtained from the Data Processing Center printouts of the claims of about 100 physicians and medical groups, from a total of 426 which had appeared above the "cutting points." On close examination, the "deviancy" of some proved to be an artifact of coding or keypunching errors, or the like. In 86 cases, the "deviancy" seemed real. For each of these cases, the Surveillance Unit prepared a narrative description of what had been found through both computer tabulations and scrutiny of claims detail, and submitted these descriptions and supporting evidence to OHCS and the fiscal intermediary for possible further inquiry and action.

During the time that it was responsible for surveillance functions, the Department of Public Health analyzed and referred, with a recommendation for further study and possible action, 379 cases of apparently "deviant" physicians, 56 podiatrists, 41 chiropractors, and 16 optometrists.† This should not be taken to mean that there were "only" 492 practitioners with questionable patterns of practice during this period. With a relatively slight increase of resources, the Surveillance Unit could have prepared reports on several times as many almost equally questionable cases. It was purely arbitrary, for example, that in the area of injection usage, the unit scrutinized the claims payment records of only those physicians with a ratio of one or more injections per patient visit. A practice with claims of 98 or 99 injections in 100 visits is scarcely less suggestive than one with 100 of each.

Fee Levels

Under Medi-Cal regulations, physicians are the only class of practitioner functioning on a "usual and customary" fee basis, rather than under a fixed schedule of maximum allowances. The question of trends in fees is therefore of interest primarily in connection with physician services.

There are advantages to examining fee levels, both by month of service and by month of payment. Some practitioners may have deferred submitting their claims until they learned from the experience of their colleagues what the operational ceilings on reimbursement were. To that extent, month-of-payment data may be the better reflection of what is actually "usual and customary," and month-of-service data may be artificially inflated by hindsight. On the

* The number was limited primarily by the Surveillance Unit's personnel limitations. During part of the period in question, the unit consisted of two statisticians. Two temporary positions were subsequently added.

† The mechanisms of subsequent review and appeal were very complex, involving not only OHCS and the fiscal intermediary but, in the case of physicians, the local medical society, California Medical Association, and, ultimately, the courts. As of this writing, five physicians, four hearing-aid firms, two physical therapists, and an ambulance company appear to have been suspended from the program. Other forms of discipline include monetary recovery, prior authorization, and warnings to reduce claims for such services as injections or routine electrocardiograms on children.

Table 5—Average payment per unit of service, three leading physician procedures, Aid to Families with Dependent Children, by month. California Medical Assistance Program, March-December, 1966 (months of payment).

Month	Procedure		
	Routine follow-up office visit	Routine follow-up home visit	Injection*
March	$4.48	$6.87	$1.19
April	5.05	8.27	1.02
May	5.24	8.14	1.37
June	5.46	8.67	1.56
July	5.52	8.82	1.59
August	5.71	9.23	1.69
September	5.75	9.71	1.71
October	5.96	9.96	1.83
November	5.84	9.60	1.89
December	5.82	9.79	1.91

* Defined by the fiscal intermediary as "9900: Necessary injections given by the physician (Medicare-Medi-Cal)." Does not include injection procedures elsewhere defined in the "Relative Value Studies" of the California Medical Association (4th ed.), 1964: 1046 (injection into joint); 1413 (injection into bursa); 2433-2440 (injections for venography, angiography, etc.); 9040 (immunizations).

other hand, month-of-payment data would be misleadingly low if the fiscal intermediary withheld payment on a substantial number of high-fee claims which, after investigation, were settled at their face value or close to it. The combination of these two influences produces month-of-service fee levels that are generally higher than those calculated by month of payment, but at present there is no way to disentangle the relative impact of the two influences.

In studying the trend in physicians' fees, another major problem arises. Medi-Cal "bought into" Title XVIII-B on behalf of all recipients who were 65 years of age or over. When Medicare benefits began on July 1, 1966, Medi-Cal was responsible only for the first $50 in physicians' payments and the 20 per cent co-payment beyond that amount. On the transaction tapes, received by the Department of Public Health from the fiscal intermediaries, co-payments were not distinguished from full payments. With the exception of data from the pre-Medicare period of March through June, 1966, the most nearly valid data on fees, therefore, were from that portion of the Medi-Cal population which is relatively rarely eligible for dual coverage by Title XIX and Title XVIII-B; i.e., the Aid to Families with Dependent Children group.

Fee trends in this categorical aid group, for the three most common types of physician procedures, are shown by month of payment in Table 5, and by month of service in Table 6.

Considered by month of payment (with the above-mentioned limitations borne in mind), average Medi-Cal payments for routine office visits increased by 29.9 per cent, routine home visits by 42.5 per cent, and injections by 60.5 per cent during the first 10 months of Medi-Cal. By month of service, the increases were 7.9 per cent, 16.5 per cent and 24.5 per cent, respectively. In some cases, there was a leveling off and even a de-

Table 6—Average payment per unit of service, three leading physician procedures, Aid to Families with Dependent Children, by month. California Medical Assistance Program, March-December, 1966 (months of service).

Month	Procedure		
	Routine follow-up office visit	Routine follow-up home visit	Injection*
March	$5.42	$8.36	$1.55
April	5.55	8.76	1.65
May	5.65	9.10	1.65
June	5.71	9.40	1.70
July	5.75	9.57	1.77
August	5.75	9.67	1.78
September	5.76	9.64	1.81
October	5.82	9.50	1.86
November	5.84	9.89	1.90
December	5.85	9.76	1.93

* Same as footnote in Table 5.

NOTE: March-September data include payments made through February, 1967; October-December data include payments made through May, 1967.

Table 7—Cases, total physician payments and physician payments per case, most common surgical procedures. California Medical Assistance Program, March-June, 1966 (months of service).

Surgical procedure	Cases*	Total physician payments†	Average physician payments per case
Tonsillectomy (2992)[a]	6,886	$888,679	$129
Normal delivery (4821)[b]	3,278	645,708	197
Lens extraction (5611)	1,443	909,939	631
Cholecystectomy (3515)	1,117	380,226	340
Inguinal hernia repair (3631)	1,100	237,794	216
Total hysterectomy (4614)	830	306,670	369
Transurethral resection of prostate (4321)	659	358,538	544

* Different recipients with each procedure at any time during the four months. One recipient may appear in more than one category.

† Includes principal surgeon's fee and anesthetist's fee if any. Does not include assistant surgeon(s) fee(s), if any.

[a] With or without adenoidectomy; under 18 years.

[b] Includes "total obstetrical care."

Note: Includes payments made through April, 1967. Numbers in parentheses are procedure codes from the California Medical Association, "Relative Value Studies," 1964 edition.

cline in average payments after October or November. Among other possibilities, this may have been due to the fact that by then 20 per cent Medicare co-payments were appearing in the data, and even the AFDC group included a considerable number of recipients 65 years of age or over—3,481 as of July 1, 1966.

Detailed Types of Services

Each type of practitioner participating in Medi-Cal has been assigned a set of procedure codes which identify with considerable precision the nature of the services rendered. Altogether, many thousands of codes are available which distinguish, for example, full maxillary alveolectomies from full mandibular alveolectomies; x-rays of the lumbosacral spine performed by a chiropractor as distinguished from a physician; and 442 different models of hearing aids.

This aspect of the surveillance "data bank" was largely unexploited. For most types of practitioners, there was little administrative demand for detailed data on types of service. One exception, though, was surgery, both because of its implications for quality of care and because of its economic implications. It is a high-cost item in itself, and is accompanied by hospitalization which often costs more than the professional fees involved. There were several limitations on Medi-Cal surgery data. Surgery performed by salaried staff physicians in county hospitals was not billed to the program as a distinct, identifiable service. All surgery data were underreported to this extent—probably in excess of 5 per cent. Furthermore, after July, 1966, information on costs of surgery was affected by the beginning of joint Title XVIII-XIX coverage, with Medi-Cal in many cases paying only a fraction of the bill. As indicated above, the claims payment tapes available to the department did not identify such cases or the fraction which Medi-Cal had paid.

The data on numbers and costs of leading surgical procedures (Table 7) are therefore limited to the March-June,

1966, service period, before the commencement of Title XVIII. If surgery utilization data from this period were projected to a full year, they would yield such rates as 10.0 hysterectomies per 1,000 adult women; 10.2 cataract operations per 1,000 persons 65 years of age and over; and 41.6 tonsillectomies per 1,000 children under 18 years of age. It may well be that these rates, which are very high by comparison with the general population, would not hold at these levels over an entire year. They may represent a backlog of elective surgery which recipients and/or physicians did not choose to have performed under California's pre-Title XIX arrangements when, for most practical purposes, surgery could be obtained by welfare recipients only in county hospitals.

Other Forms of Surveillance

Hospital Utilization

Over a third of all Medi-Cal payments to date have gone to hospitals. Surveil-

Table 8—Average days of stay for selected diagnostic categories, county and community hospitals, Northern and Southern California. California Medical Assistance Program, January-May, 1967 (months of payment).

Diagnostic category	Northern California* hospitals		Southern California† hospitals	
	Community	County	Community	County
Total, following categories	6.7	10.0	6.1	8.2
Arteriosclerotic and degenerative heart disease (420-422)	13.8	16.4	13.3	17.0
Hypertensive heart disease (440-443)	12.7	15.5	11.1	35.8
Pneumonia (490-493)	8.9	7.8	8.6	9.1
Bronchitis, bronchiectasis, emphysema (500-502, 526-527)	9.2	11.0	8.6	14.6
Hypertrophy of tonsils and adenoids (510)	1.9	2.1	2.1	2.4
Ulcer of stomach or duodenum (540-541)	12.1	7.7	11.3	12.4
Appendicitis (550-553)	6.4	5.5	7.1	6.3
Abdominal hernia (560)	7.7	6.9	7.0	7.6
Abdominal hernia with obstruction (561)	5.7	9.1	9.3	10.8
Cirrhosis of the liver (581)	16.0	17.7	15.0	15.0
Cholecystitis, other diseases of the gallbladder (584-586)	10.9	8.6	11.1	12.0
Complications of pregnancy, delivery, puerperium (640-649, 670-678, 680-689)	3.6	3.1	3.8	3.5
Abortion (650-652)	2.7	2.9	3.2	2.7
Normal delivery (660)	3.7	3.0	3.2	3.5
Arthritis and rheumatism (721-727)	16.4	15.4	15.4	19.6
Pneumonia, asphyxia, and atelectasis of newborn (762-763)	17.7	7.4	9.2	8.2
Immaturity (776)	14.4	7.4	14.8	11.3
Senility and ill-defined (790-795)	15.9	17.9	10.1	14.1

* Includes 45 counties for which the Hospital Service of California (Blue Cross) serves as fiscal intermediary.
† Includes 13 counties for which Blue Cross of Southern California serves as fiscal intermediary.
Note: Derived from paid billings, of which some covered more than a full month of service while others were submitted before service (length of stay) was completed. Underlined averages based on fewer than 25 cases. Numbers in parentheses are from the seventh revision of the International Statistical Classification of Diseases, Injuries, and Causes of Death.

Table 9—Average payment per day for selected diagnostic categories, county and community hospitals, Northern and Southern California. California Medical Assistance Program, May, 1967 (month of payment).

Diagnostic category	Northern California* hospitals		Southern California† hospitals	
	Community	County	Community	County
Arteriosclerotic and degenerative heart disease (420-422)	$51.98	$27.04	$ 46.05	$32.86
Hypertrophy of tonsils and adenoids (510)	80.44	59.37	88.83	50.30
Appendicitis (550-553)	63.34	60.15	65.84	55.51
Complications of pregnancy, delivery, puerperium (640-649, 670-678, 680-689)	78.29	54.78	78.68	58.68
Abortion (650-652)	83.14	62.59	107.65	57.99
Normal delivery (660)	72.34	75.43	74.47	50.51

* Includes 45 counties for which the Hospital Service of California (Blue Cross) serves as fiscal intermediary.
† Includes 13 counties for which Blue Cross of Southern California serves as fiscal intermediary.
NOTE: Does not include portions of billings paid by Title XVIII, private health insurance, or personal liability. Includes payments for all services billed by hospital: room and board, operating room, laboratory, x-ray, drugs, etc. Numbers in parentheses are from the 7th Revision of the International Statistical Classification of Diseases, Injuries, and Causes of Death.

lance in this, the largest sector of the program, has been particularly difficult, however, due to inconsistencies in the transaction tapes. Month-of-service information has so far been impossible to reconstruct. For several months of payment, however, certain basic types of utilization information have been retrieved, as illustrated in Table 8.

There appear to be several noteworthy differences between the average lengths of stay for comparable diagnostic categories in county and community hospitals in Northern and Southern California. Although the differences do not lie in a consistent direction, there is a tendency for stays to be longer in county than in community hospitals.

Hospital cost data, as shown in Table 9, are suggestive but inconclusive. Medi-Cal payments range from an average of less than $20 per patient day in county hospitals for certain chronic conditions to more than $90 per patient day in community hospitals for certain acute conditions. Much of the difference is accounted for by joint Medicare coverage in conditions found principally among recipients 65 years or over—exactly how much, one cannot say, since co-payment information was not provided to the Surveillance Unit by the fiscal intermediaries.

Duplicate Billings and Payments

Month-of-service files, scanned by an appropriate computer program, reveal that more than one payment is sometimes made for the same service. Preliminary investigations of this subject by the Surveillance Unit and Data Processing Center, in cooperation with OHCS auditors, suggested that duplicate payments on the order of $100,000 were made by one fiscal intermediary in the one month studied.

Physician Visits by Diagnosis

The Surveillance Unit did relatively little analysis of physician services by diagnosis, principally owing to shortcomings in the accuracy of diagnostic

reporting and coding.* However, one computer program was devised which tabulated all diagnostic codes to appear in a given month by the number of "episodes of illness" in which they appeared, and the number of physician services received in each episode. Table 10 indicates the diagnoses which appeared in the most "episodes" in the October, 1966, month of service. Of particular interest, perhaps, are the conditions which received 15 or more services during the month, including 140 common colds, 98 ill-defined and unknown causes of morbidity, 96 cases where no diagnosis at all was given, and 44 cases of "observation without need for further medical care." Many of these seeming incongruities, it may be assumed, were the result of errors in diagnostic coding. Others presumably represented over-utilization.

Epidemiology

The enormous Medi-Cal "data bank" affords rich opportunities for epidemiological studies. In a health survey of 1,500 households, for example, there may be only a handful of cases of conditions that are of interest to public health authorities. Problems of informant recall, and the like, make it even more difficult to arrive at constructive hypotheses in regard to the distribution of these conditions by time, space, age, sex of patient, or other variables. Within the Medi-Cal system, there is rather complete information, undistorted by the fallibilities of the lay memory, on the care received by all members of well over half a million households, as long as they

* Original billings were not routinely available to the Surveillance Unit, but on one occasion it was possible to examine 70 claims, and compare their descriptions of diagnoses with the diagnostic codes which eventually appeared on the transaction tapes sent to the department by the fiscal intermediary. In 16 cases, the diagnoses had clearly been coded correctly; in 7 cases, there were uncertainties; in 47 cases, the coding seemed clearly inadequate.

Table 10—Physician services per episode for twelve most common diagnoses. California Medical Assistance Program, October, 1966 (month of service).

Diagnosis	Physician services							
	Total	1	2–3	4–5	6–7	8–9	10–14	15 or more
Acute upper respiratory infection of multiple or unspecified sites (475)	29,290	11,474	11,378	3,664	1,452	648	534	140
Essential benign hypertensive heart disease (440)	24,176	9,639	8,872	3,083	1,151	673	568	190
Arteriosclerotic heart disease (420)	20,307	7,008	7,316	2,877	1,077	698	757	574
No diagnosis given	16,551	10,452	4,101	1,165	365	193	179	96
Ill-defined and unknown causes (795)	13,570	7,127	4,290	1,153	495	222	185	98
Diabetes mellitus (260)	13,538	3,474	5,351	2,289	957	592	539	336
Observation (793)	12,934	6,223	5,368	940	232	74	53	44
Acute bronchitis (500)	12,909	3,472	5,009	2,269	1,102	474	433	150
Tonsillitis (473)	9,910	3,023	4,046	1,540	714	314	227	46
Other and unspecified diseases of the heart (434)	7,272	2,251	2,556	1,168	454	289	327	227
Other diseases of eye (388)	7,156	4,941	1,691	400	93	18	12	1
General arteriosclerosis (450)	7,119	2,999	2,481	839	323	180	189	108

Note: Numbers in parentheses are from the 7th Revision of the International Statistical Classification of Diseases, Injuries, and Causes of Death.

remain eligible for benefits. These benefits, in the case of aged, blind, and disabled recipients particularly, usually cover an extensive period of time, often the entire balance of their lives. Within a population of this size, substantial numbers of comparatively esoteric conditions might be located and followed either retrospectively or prospectively.

The Surveillance Unit prepared a list of 112 diagnoses which were of interest to epidemiologists in other bureaus of the Department of Public Health, and the unit requested preparation of a computer program that would list all physician and other services received by each recipient with any of these diagnoses. However, this program could not be made operative by the time Medi-Cal research responsibilities were removed from the department, with its epidemiological and preventive medical concerns.

Quality of Care

Perhaps the most basic of the charges to the Surveillance Unit, and the most difficult, was to conduct studies to ascertain whether Medi-Cal recipients were "receiving care . . . equal in quality to other portions of the population." Much of the work of the unit shed indirect light on this question. For example, the high rate of tonsillectomies discovered by the unit was significant far beyond the fact that these procedures have probably cost the program over $10 million to date. Most pediatricians feel that, under contemporary conditions, surgery is usually not the procedure of choice in hypertrophy of the tonsils. For another example, data on the use of injections within the program suggested that in this respect many Medi-Cal patients were receiving a type of care quite different from the general population. A number of similar inferences could be drawn from data on radiology, and so forth.

In many other respects, however, the quality of care under Medi-Cal still awaits illumination. For instance, the amount of prenatal care received by AFDC mothers could be studied from present data, as could the immunization levels of AFDC children. There are possibilities for linkages between the Medi-Cal eligibility file and the department's files of death certificates, and for calculation of infant, maternal, cause-specific, age-adjusted, and other forms of death rates.

Other possibilities—many of them with implications for quality of care—lie in linkages between Medi-Cal claims payment tapes and the Medi-Cal "vendor file," which includes such information as physicians' specialties, and whether or not they are board-certified.

Beyond this, the question of whether recipients of Title XIX benefits (and benefits under other new health programs) are receiving a quality of care commensurate with community standards requires enhanced knowledge about the care received by "other portions of the population." This, in turn, requires far greater resources for medical care studies than were available to the Surveillance Unit at any time.

Conclusion

Within the recent past, a confluence of two developments with profound implications for medical care organization and administration has taken place in the United States. First, there was a rising demand that society should assume more responsibility to protect its members against the exigencies of ill health. After many years, this demand mounted to such a point that it could no longer be denied. Society began by assuming responsibilities for assisting those who were least able to assist themselves: most notably the aged and the poor. Although these were "minority" groups, their numbers were sufficiently large and their health needs so great that the flow of records within the new programs dwarfed anything previously experienced in medical care programs in this country.

It is difficult to see how the programs could have operated under old methods of claim examination and payment. Fortuitously, during the same years that the demand for these new health programs was mounting, electronic engineers and other technologists were developing, among many other applications, instruments capable of coping with the enormous flow of data within the new programs. It was a case of the right technological development and the right social development coming together at the right time.

The marriage is far from fully consummated. The possible uses of computers within the new health care programs have scarcely been touched. To date, technology has been used primarily for its value in speeding the claims payment process. That is the merest beginning. Computers can and will play a much larger and more important role in the area of evaluation—or, as it was called in the California Department of Public Health, "surveillance"—of the quantity and quality of care being purchased through the claims payment process.

This will require modifications in some current practices and attitudes. Claim forms carried over from an era of hand-processing will have to be redesigned. Practitioners will have to record information more accurately. In some cases, more sensitive coding protocols will need to be developed. Better trained coders are essential. And in all participating agencies, at all levels, something amounting almost to a "new breed" of medical care administrator is needed. Among other qualifications, this administrator will have at least nodding acquaintance with the present generation of computers and what they can and cannot do; be sensitive to the subtleties of good quality health care and that which is less than good; be able to conjure creatively with such social, political, and economic realities as the fact that there are tendencies in the present organization of health care that press toward higher costs while, on the other hand, society's increasing open-handedness in this area is not without limits.

Lawmakers, administrators, practitioners, recipients, and the public at large, will be asking more frequently and more insistently: "Are these new programs achieving their intended purposes?" The programs are so vast that answers will be forthcoming only to the extent that computer capabilities are increasingly exploited. It is perhaps not putting the case too strongly to say that the new programs will not survive without computerized surveillance.

But it is probably equally true that the new programs will not survive with computerized surveillance alone. For example, one cannot visualize a provider of health services being judged guilty of providing an unacceptable quality of care, and removed from a program, solely on the basis of his statistical record. Computers can provide the statistical records, as no army of clerks could, but they cannot sit in judgment. They are tools in the hands of men—indispenable tools—and should be more widely recognized and accepted for what they can do. However, men themselves will continue to be responsible for assigning tasks to those tools, and for passing ultimate judgment upon the results.

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INDEX -- Lester Breslow*

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Ronald Reagan Era, 1966-1974
Interviews Completed or In Process, June 1985

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Tuttle, Holmes

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Canson, Virna, UC Berkeley.
Carleson, Robert, UC Berkeley.
Carter, Louis, UC Berkeley.
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Chickering, Sherman, UC Berkeley.
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Goodlett, Carlton B., UC Berkeley.
Hall, James, UC Berkeley.
Hampton, Claudia, UC Berkeley.
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Lane, Melvin, UC Berkeley.
Livingston, Donald, UC Berkeley.
Lowry, James, UC Berkeley.
Luce, Gordon C., UC Berkeley.
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Miller, Anita, UC Berkeley.
Mott, William Penn, UC Berkeley.
Orr, Verne, UC Berkeley.
Reagan, Ronald, UC Berkeley.
Reinecke, Edwin, UC Berkeley.
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Stearns, James, UC Berkeley.
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